ALASKA LEGISLATURE COMMITTEE FILES 2007-2008 SL&C 12627

SB

170

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 5/14/07

FURTHER: Health, Education and Social Services
Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/26/08

Labor and Commerce Committee considered SENATE BILL NO. 179

SB 179 DEPENDENT HEALTH INSURANCE; AGE LIMIT

"An Act requiring family health care insurance coverage for dependent children who are less than 26 years of age."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [X] **CS** SB 179 (L+C)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[X] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#
HSS	2/27/08		✓		

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
	Burke		✓		
Betty Davis	DAVIS	✓			
	STEVENS			X	
CHAIR	ELLIS	✓			

ALASKA STATE LEGISLATURE

Session
State Capitol Building, Room 125
Juneau, Alaska 99801-1182
Phone (907) 465-2995
Fax (907) 465-6592

Interim
716 West Fourth Avenue, Suite 430
Anchorage, Alaska 99501
Phone (907) 269-0250
Fax (907) 269-0249

Chair
Senate State Affairs
Administrative Regulation Review

Member
Senate Judiciary Committee
Senate Resources Committee

SENATOR LESIL MCGUIRE

Sponsor Statement
Senate Bill 170: "Insurance Coverage for Well-Baby Exams"

SB 170 would require private health insurance plans to include in their standard coverage for dependents "well-baby" exams. These exams, considered a part of routine pediatric health supervision, are often referred to as "well-child" exams or "well-child" care. They are commonly known as infant check-ups and are estimated to cost between $125 and $250, not including immunizations. At least twenty-one states require commercial insurance companies to cover some level of well-child care.

This bill would require "well-baby" exams for infants during their first 24 months of life. Those exams include monitoring development and growth rates, hearing, vision, language skills, motor development, diet, general and preventative health care, immunizations, and infectious diseases. A wide consensus exists that certain preventative interventions improve health outcomes and are cost-effective. This bill ensures that Alaskan babies receive as a matter of course the best preventative health care possible.

LEGISLATIVE RESEARCH REPORT

APRIL 10, 2007

REPORT NUMBER 07.113

INSURANCE COVERAGE FOR WELL-CHILD EXAMS

PREPARED FOR SENATOR LESIL MCGUIRE

BY CHUCK BURNHAM, LEGISLATIVE ANALYST

907-465-3991
907-465-3908 (fax)

Alaska Legislature
Legislative Research Services
w3.legis.state.ak.us/Research/research_home.htm

State Capitol
Juneau, AK 99801

You asked about health insurance coverage for "well-child" examinations. Specifically, you wanted the following information:

- The number of states that require insurance companies to provide coverage for well-child exams;
- Provisions of those requirements, including the number and frequency of exams required to be covered and the obligations, if any, that such laws place upon the insured;
- Research showing the health impacts of well-child examinations; and
- Potential impacts to Alaska of requiring coverage of well-child exams including benefits, negative consequences, and impacts on the uninsured.

SUMMARY

Since being incorporated into the U.S. health system in the 1930s, routine pediatric health supervision—commonly known as "well-child" care or well-child exams—has become a cornerstone of the nation's preventive healthcare.[1] At least twenty-one states require commercial insurance companies to cover some level of well-child care; however, among these states the health services and the number of exams that must be covered vary widely.

Despite the efforts of government agencies and others in recent years, high quality clinical research into the effectiveness of well-child exams is relatively scarce. This circumstance creates difficulties for healthcare providers, policy-makers, and parents when weighing the costs and benefits of providing or funding well-child care. Clearly, for certain population groups—in particular children of low-income families, who are most likely to suffer from chronic illness—certain aspects of well-child exams appear highly beneficial. Beyond immunizations, however, the battery of well-child services suggested in the schedules recommended by groups like the American Academy of Pediatrics (AAP), when delivered to healthy children, may incur costs unnecessarily and further strain an already burdened healthcare system.

Two things are true of nearly all state insurance mandates: they provide increased access to services and protection to consumers, and they raise premium costs. The question with regard to mandating well-child coverage in Alaska, then, is as follows: would the benefits gained by expanding preventive services outweigh potential increases in insurance premiums and the associated possible loss of coverage? Unfortunately, with the data available to us, we cannot conclusively answer this question. There exists wide consensus that certain preventive interventions improve health outcomes while remaining cost-effective—particularly when those services are targeted to population groups at increased risk for chronic illnesses. With the limited data available to us, however, it is not possible to determine the overall impact of mandating all well-child care services recommended by the AAP and others.

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[1] In this report the terms "well-child" and "well-baby" exams or care are used interchangeably. Significant variation exists in the composition of these exams among various jurisdictions and healthcare providers. In general, the visits include a mixture of health interventions delivered by a pediatrician or other healthcare provider according to a specified schedule throughout childhood. The interventions most commonly include behavioral counseling (sleep positioning, violence prevention, etc.), health screening (testing for iron deficiency, vision impairment, etc.), and delivery of prophylaxis (immunization, vitamin supplementation, etc.).

It is clear that mandating commercial insurance companies to cover well-child care would directly result in increased preventive care for only a portion of the state's children. About 47 percent of Alaskan children either receive public insurance benefits, which include access to robust well-child care, or are uninsured. The remaining 53 percent receive employer-based or some other form of private insurance. Although this is the type of insurance that a mandate would impact, a majority of such plans may already cover some aspects of well-child care (most often immunization and physical exams, at a minimum). With the data to which we have access, it is not possible to determine the number of children who would receive access to "new benefits" through a well-child mandate.[2]

Denali KidCare, Alaska's combination Medicaid and State Children's Health Insurance (SCHIP) program, provides access to comprehensive well-child benefits for low-income children as required by the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). The services in this program are generally more comprehensive than those provided by private insurers, yet research has shown that Medicaid's coverage of children is, on average, less expensive than private coverage. However, like many other states, Alaska struggles to enroll all of its eligible children. Particularly troublesome is that data from the U.S. Census Bureau show that the very young children (ages 0-6 years) of the lowest income families (under 100 percent of the federal poverty threshold) are also the least likely to be enrolled. Although the federal government is now requiring that states increase efforts to meet an 80 percent participation threshold, enrollment is not the sole issue. Of the Alaska children who are enrolled in Denali KidCare, only about half receive the well-child exams to which they are entitled. This lack of utilization is likely the result of a number of factors, including lack of access to healthcare providers and parents being unaware of available benefits. The combination of under-enrollment and low utilization of benefits means that there are thousands of Alaska children who currently qualify for well-child benefits, but do not receive those services.

Other states appear to have successfully increased delivery of well-child services by combining public insurance with private coverage of cost-effective services that have shown to improve health outcomes. Five of the seven states that currently exceed the federal goal of enrolling 80 percent of eligible children for EPSDT benefits have expanded both initial eligibility requirements for public insurance (at least 200 percent of federal poverty guidelines) and mandates for commercial well-child coverage.

Regardless of the strategies pursued, when considering mandating coverage of well-child care, Alaska-specific actuarial analyses of the cost-effectiveness of delivering individual preventive services to specific population groups may be the best means of determining which benefits would best serve the state's children.

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[2] The number of children who would receive new benefits depends largely on two factors as follows: the services to which children currently have access, which we cannot determine largely due to confidentiality provisions of insurance carriers and state regulators, and the specific mandates that may be enacted in law.

PRIVATE INSURANCE COVERAGE OF WELL-CHILD EXAMS IN THE STATES

At least twenty-one states require private health insurance plans to include coverage of well-child exams based on the "Recommendations for Preventive Pediatric Healthcare," or "periodicity schedule," published by the American Academy of Pediatrics (AAP).[3] Few of these states, however, require coverage of all of the procedures in the complete periodicity table. Indeed, states vary widely in the number and types of procedures covered, the years for which coverage is required, and whether the exams are exempt from deductible, co-pay, and coinsurance charges. For instance, New York requires very broad coverage of the AAP recommendations from birth to age twenty and exempts the costs for those exams from deductibles and coinsurance. By contrast, Montana requires coverage only through age three and allows companies to charge a co-pay and coinsurance for related exams and treatments.[4]

Other than deductibles, co-pays, and coinsurance, we located no requirements of or obligations placed upon the insured as a result of laws requiring coverage of well-child exams. Specifically, we found no requirement that insured parents make use of well-child benefits.

RESEARCH ON WELL-CHILD EXAMS

Assessing the overall effectiveness of well-child exams is complicated by a number factors. First, we were unable to locate high quality evidence-based studies of the impact of the exams as whole—that is, the specific combination of screening, preventive treatment, and counseling that are generally included in these exams. Indeed, with the notable exception of childhood immunizations, rigorous research designs such as randomized clinical trials have rarely been applied to individual components of the exams, much less for the well-child regimen as a whole. Second, even where a particular service can be shown to provide benefits, those benefits may not justify the costs for delivering that service to all children.

THE EVIDENCE BASE

The U.S. Department of Health and Human Service established the U.S. Preventive Services Task Force (USPSTF) in 1984 to give health care professionals advice about which forms of preventive care should be routinely offered to patients who exhibit no symptoms of illness.[5] In order to be recommended by the USPSTF, a given service must first undergo rigorous, impartial

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[3] Those states are Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Mexico, New York, Ohio, Oklahoma, Rhode Island, Texas, Virginia, and Wisconsin. Additional states require coverage of individual procedures—metabolic testing and hearing screening, for example—but do not compel coverage of the comprehensive exams recommended by the AAP. We include a copy of the AAP periodicity table as Attachment A.

[4] We include a table prepared by the AAP, which provides details on states' requirements for coverage of well-child exams, as Attachment B. Jody Ruskamp-Hatz, Senior Policy Specialist, National Conference of State Legislatures, (303) 856-1521, provided this table. According to Ms. Ruskamp-Hatz, most laws requiring coverage of well-child exams were enacted due to the advocacy of the AAP for the "Child Health Insurance Reform Plan" (CHIRP).

[5] Extensive information about the USPSTF and its recommendations are available online at *http://www.ahrq.gov/clinic/cps3dix.htm#pediatric.*

assessments of the scientific evidence of its effectiveness. Since its inception, the Task Force has been widely viewed as the "gold standard" for definitevly establishing the importance of including prevention in primary health care; however, due to the very high standards of evidence required, relatively few services have received the recommendation of USPSTF for delivery to asymptomatic children who are at average risk for illness. Table 1 compares the recommendations of the USPSTF to those of the "well-child" periodicity schedule of the AAP for a child of twelve months.[6]

[6] Clearly, both the AAP and the USPSTF promote the value of preventive medicine, and the variations among their recommendations may not reflect disagreements between the two groups, but rather result from the organizations' differing missions and methods. The USPSTF is widely recognized as having among the most stringent evidence-based standards in reviewing preventive health services prior to recommending those services be administered widely. By contrast, although the AAP supports its recommendations with some degree of clinical evidence, the organization uses an "expert consensus" method. In addition, the AAP may be more concerned with establishing a "continuum of care" for *individual* patients through frequent and comprehensive exams than with absolute clinical certainty of the value of a service to the *entire population*.

Table 1: Comparison of USPSTF and AAP Preventive Services Recommendations for a Child of Twelve Months

Service[1]	AAP		USPSTF	
	Patient Risk Factors[2]			
	Average	Increased	Average	Increased
Anemia (iron deficiency) Screening	X		I	B
Developmental/Behavioral Assessment	X			
Hearing Screening	X		I[3]	
Hereditary/Metabolic Screening	X		Currently being updated	
Hip Displaysia Screening			I	
Immunization	X		X[4]	
Injury Prevention	X			
Lead Screening		X	D	I
Nutrition Counseling[5]	X			
Oral Fluoride Supplementation			B	
Physical Activity Counseling			I	
Skin Cancer Counseling			I	
Tuberculin Test		X		
Urinalysis	X			
Violence Prevention	X		I	
Vision Screening	X		B	

Legend: American Academy of Pediatrics (AAP): **X** - Recommended; U.S. Preventive Services Task Force (USPSTF) "grading" system: **A** - Strongly recommended; **B** - Recommended; **C** - No recommendation; **D** - Not recommended; **I** - Insufficient evidence to make determination.

Notes: The AAP and the USPSTF both promote the value of preventive medicine. Differences among their recommendations may not reflect disagreements between the two groups, but rather may result from the organizations' differing missions and methods. The USPSTF is widely recognized as having among the most stringent standards in reviewing preventive health services prior to recommending those services be administered widely. By contrast, the AAP may be more concerned with establishing a "continuum of care" for individual patients through frequent and comprehensive exams.

1) These are the services that one or both of the groups recommend for asymptomatic children at age 1 (twelve months). A blank space in the AAP columns indicates this service was not included in the group's schedule of preventive services. A blank in the USPSTF columns indicates that the task force has not issued an opinion on the service. Recommended services vary by age for both organizations.

2) Each organization publishes guidance regarding increased risk factors for children of various ages. For instance, the USPSTF considers status as a recent immigrant and low birth-weight and premature birth to be risk factors for anemia.

3) The USPSTF does, however, recommend hearing screening at birth.

4) Although it issues no immunization recommendations, the USPSTF endorses the joint recommendation of the AAP and the Centers for Disease Control, which is widely accepted as the official immunization schedule of the U.S.

5) The USPSTF recognizes the importance of nutrition and has reviewed data on the health risks of obesity in children; however, this is an example of a service for which there is insufficient evidence showing the positive and negative results of counseling. As a result, the organization has not issued a recommendation for nutritional counseling and has found insufficient evidence ("I") for obesity screening in children aged 6 and older.

Sources: American Academy of Pediatrics, Committee on Practice and Ambulatory Medicine, online at http://aapgrandrounds.aappublications.org/cgi/content/full/pediatrics;105/3/645; U.S. Preventive Services Task Force

The differences between the recommendations of the USPSTF and the AAP are illustrative of the environment of confusing and often conflicting information in which healthcare providers, policymakers, and others are operating with regard to well-child exams. A group of researchers

who reviewed numerous studies in an attempt to assess the value and efficacy of well-child exams found that

> taken together, the literature evaluating the effectiveness of well-child care is perhaps more remarkable for its limitations that for its findings.[7]

Those words were written in 1989. Despite the efforts of the USPSTF and others in the intervening years, it does not appear that the situation has improved significantly.

A 2004 study that reviewed the well-child recommendations of seven major North American health organizations found hundreds of discrete recommendations, and forty-two separate preventive interventions for children that were variously recommended by two or more of the organizations studied.[8] Despite the dozens of recommended services, the researchers reported that they found "limited direct evidence" to support the recommendations. Although delivering preventive services, even in the absence of clinical data may appear benign, perhaps even wise, these researchers concluded otherwise, as follows:

> Because a large number of interventions are routinely recommended and often mandated and because the implementation of any recommendation may cause harm (including the displacement of other beneficial activities), these recommendations should be based on the strongest possible evidence. When recommendations are made, supporting evidence should be clearly stated.[9]

Governments at all levels may have to take more active roles in developing the evidence base for well-child exams. In the meantime, however, scarce data, and the discrepancies in recommendations from well-respected organizations, require that healthcare providers, policy-makers, and parents make often difficult decisions in prioritizing limited healthcare resources.

WEIGHING COSTS AND BENEFITS

Critically discussing the costs of well-child exams in public arenas is often challenging because if a given service has a chance of improving the health of children it is difficult to deny that service, even where evidence of its efficacy is relatively weak. Nonetheless, in an age of rapidly increasing healthcare costs and intense competition for healthcare dollars, policy-makers and others may have little choice but to prioritize services according to their costs and benefits in relation to other services. This is particularly true in light of the fact that governmental well-child policies impact not only those who are covered by Medicaid and other public health programs, but also the insurance companies that are "mandated" to provide coverage of well-baby visits in nearly half of the states and, ultimately the consumer who may bear increased costs in a number of ways. Moyer and Butler emphasized this point in the following discussion:[10]

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[7] Judith L. Wagner, Roger C. Herdman, and David W. Alberts, "Well-Child Care: How Much is Enough?" *Health Affairs*, Vol. 8, No. 3; Fall 1989. We include a copy of this article as Attachment C.

[8] Virginia A. Moyer, M.D., M.P.H., and Margaret Butler, B.A., "Gaps in the Evidence for Well-Child Care: A Challenge to Our Profession," *Pediatrics*, Vol. 114, No. 8; Dec. 2004. We include a copy of this article as Attachment D.

[9] Moyer and Butler, p. 1511.

[10] Moyer and Butler, pp. 1516-1517.

> The costs and potential adverse effects of the recommended aspects of well-child care have not been evaluated adequately. Costs include not only the direct costs of physician and staff time, laboratory costs, and costs of agents used in prophylaxis but also costs to parents, such as time lost from work and costs of transportation.

As the authors say, these costs become increasingly burdensome if they cannot be justified by the benefits produced, particularly in light of the increased demands the exams place on the healthcare system:

> When ineffective or less effective interventions displace more effective interventions, children are deprived of the more effective interventions. Although time per [healthcare] visit has increased, the average remains [approximately] 15 minutes . . . it would require 7 to 8 hours per working day for a primary care physician to provide the preventive services recommended by the USPSTF, making it unfeasible to provide even this limited list of preventive services within the current structure of practice.

MEASURES OF COSTS AND BENEFITS[11]

There are a number of ways in which to weigh costs and benefits of health policy, the most comprehensive of which are quite complex, often requiring analysis by an actuary specializing in healthcare. Perhaps the most common of these methods are variations of "cost analysis," "cost-benefit analysis," and cost-effectiveness analysis," which are briefly defined as follows:

> **Cost analysis**—calculates the net cost of a policy by subtracting the value of illnesses prevented by the policy from the cost of implementing that policy (the "cost of prevention"). When a policy has a negative cost—that is, the value of illness prevented is greater than the cost of prevention—the intervention is said to be a cost-saving policy.
>
> **Cost-benefit analysis**—compares the cost of a policy to improvements in health as measured in dollars by subtracting the dollar value of health improvements from the cost of prevention.[12] Frequently, results of these analyses are expressed as a cost-benefit ratio with benefits on top and costs on the bottom (dollar value of health improvement / cost of prevention). A policy is generally viewed as worthwhile if the cost-benefit ratio is greater than one, which indicates the benefits are greater than the costs.
>
> **Cost-effectiveness analysis**—allows comparison of health policies by dividing the value of the health improvement achieved by the policy by the net cost of that

[11] The following two sections are summarized from "What Policymakers Need to Know About Cost Effectiveness," *Partnership for Prevention*, 2001. Partnership for Prevention identifies itself as a membership organization of businesses, nonprofit organizations and government agencies advancing policies and practices to prevent disease and improve the health of all Americans. We include this document as Attachment E. Further information is available on the group's website at *http://prevent.org/content/view/5/20/*.

[12] This method of cost-benefit analysis is specific to healthcare. The dollar value of health improvements is a measure that includes a degree of subjectivity and, at times, controversy. In depth discussion of such measures are outside the scope of this report. Additional information on measuring the economic burden of illness is included in Attachment E.

policy. This calculation creates a figure that can represent the value of a number of designated outcomes. For example, the analysis could be designed to compare the relative value of *deaths averted* for two screening procedures, the *per year* savings of those interventions, or the *per injection* value of several vaccines. Therefore, unlike cost analysis and cost-benefit analysis, cost-effectiveness analysis is designed to show which policies require fewer resources to achieve health benefits *compared to other interventions*, but does not necessarily indicate whether a policy produces net savings.

In general, it appears that cost-benefit analyses of well-child exam services, particularly those that are not supported by convincing clinical evidence, provide policymakers with the most useful information with which to make an "apples-to-apples" comparison of the relative value of interventions.

THE COST OF INSURANCE MANDATES

There exists fairly wide consensus that governmental mandates that commercial insurance policies include coverage of specific benefits raises the cost of insurance to consumers. There is no consensus, however, on the amount of increases such mandates generate. In 2003, the U.S. General Accounting Office (GAO) reviewed studies of the costs of state mandates. The GAO found wide variation in published estimates of increases in premiums attributable to mandates, from a 3.4 percent increase in premiums in Maryland, to a study in Virginia that claimed mandates accounted for nearly thirty percent of premiums. Some of this variation can be explained by the fact that the number and type of mandates varies among the states. In addition, some studies of mandates did not consider the fact that many state mandated benefits would be offered by insurance companies—either as an option or as a standard service—in the absence of mandates. In such cases, state mandate laws cannot be said to be responsible for the full portion of the premiums that are attributable to the service mandated. In studies that evaluated the marginal costs of mandates—those that likely would not be offered in the absence of a mandate—premium increases due to mandates were typically less than ten percent.[13]

Research specifically into increases in premiums due to mandating well-child exams appears to be relatively rare. One study by the Council for Affordable Health Insurance claims that well-child mandates represent one percent to three percent of premiums in the states that require such coverage. This study did not take into account whether such services would be provided absent a mandate; neither, however, does the study's definition of well-child care appear to include all of the services recommended by the AAP periodicity table.[14] One of the primary concerns with mandates is that they may actually reduce coverage for certain consumers by raising premiums to the extent that individuals or employers are forced to reduce or eliminate coverage. Although premiums in the state would likely increase to some degree, in the absence of additional data we are unable to determine what impact a well-child exam mandate would likely have on the level of insurance coverage in Alaska.

[13] The GAO report is available online at *http://www.gao.gov/new.items/d031133.pdf*.

[14] The Council for Affordable Health Insurance is a research and advocacy group made up of insurance carriers. Its report on mandates is available online at *http://www.cahi.org/index.asp*.

IMPACTS OF REQUIRING COVERAGE OF WELL-CHILD EXAMS IN ALASKA

In general, it appears that health insurance "mandates" are both beneficial and costly to consumers. Mandates are popular because they provide consumers greater access to services, particularly preventive services, which commercial insurers may not otherwise cover. This expanded coverage should lead to avoidance or earlier detection of health issues, which may produce long-term savings in health spending and increased quality of life. However, opponents of mandates point to studies showing that mandated benefits increase costs to consumers, forcing employers and individuals to reduce their level of coverage or even forego insurance altogether, resulting in fewer insured individuals.[15] The question with regard to mandating well-child coverage in Alaska, then, is as follows: **would the benefits gained by expanding preventive services outweigh potential increases in insurance premiums and the associated possible loss of coverage?**

Unfortunately, with the data available to us, we cannot conclusively answer this question. To be clear, there exists wide consensus that certain preventive services improve health outcomes. Some of these services likely prove to be sound investments for healthcare dollars because they avert costly treatments for chronic illnesses. This is particularly true of services targeted to population groups who are at increased risks for certain illnesses. Nonetheless, with the exception of childhood immunization, we find no source to state with certainty that mandating commercial insurance coverage of the combination of services suggested by groups such as the AAP will provide benefits (improved health outcomes and long-term cost savings) that will outweigh increases in premiums and the potential loss of health coverage for some number of residents that may result. To address these questions fully, you may wish to consult an actuary specializing in healthcare policy.

CURRENT WELL-CHILD COVERAGE IN ALASKA

The extent of well-child exam coverage for Alaska children currently depends on several factors including **healthcare coverage status, whether parents take advantage of the well-child benefits that are available to them, and family income level**. Table 2 shows the status and type of healthcare coverage for Alaskans compared to the national average for children aged 0 to 18 years.

[15] We include, as Attachment F, "Mandated Health Insurance Benefits: Tradeoffs Among Benefits Coverage, and Costs?" *California Health Policy Roundtable* (a *Kaiser Family Foundation* funded organization), July 2002.

Table 2: Type of Healthcare Coverage of Children Aged 0-18 in Alaska and the U.S., 2004				
Type of Coverage	Alaska		United States	
	Individuals	Percent	Individuals	Percent
Employer	96,160	49.3%	43,899,504	56.4%
Individual	7,210	3.7%	3,502,620	4.5%
Medicaid	60,210	30.8%	20,470,868	26.3%
Other Public	13,790	7.1%	1,089,704	1.4%
Uninsured	17,880	9.2%	8,873,304	11.4%
Total	195,240	100.0%	77,836,000	100.0%

Notes: Percent figures do not sum to 100 percent due to rounding. Alaska's proportion of children covered by "other public" insurance exceeds that of the U.S. population due in large part to children covered by the Indian Health Service.
Source: Kaiser Family Foundation, from U.S. Census data; available online at *http://www.statehealthfacts.org*.

Our analysis of the data in Table 2 indicates that the pool of children who would be impacted by mandating well-baby coverage is somewhat limited. Well-child benefits are currently available to those covered by Medicaid and "other public" insurance, which includes the Indian Health Service, primarily under the federally mandated Early and Periodic Screening Diagnosis and Treatment program (EPSDT). (We discuss this program in greater detail below.) Mandating commercial coverage would provide no new benefits to the uninsured. Therefore, the remaining pool of approximately 103,000 children—those covered by employer-based or individual insurance—represents about 53 percent of all children aged 18 or younger. This is not to say, however, that 53 percent of Alaskan children would substantially benefit from mandated well-child coverage, because a number of the state's insurers already provide some level of well-child benefits. For instance, Premera Blue Cross, which, according to the Department of Commerce Community and Economic Development, Division of Insurance, underwrites about 78 percent of the comprehensive health insurance policies in the state, includes immunizations and preventive office visits in its group plans.[16] Such coverage is limited, however, and it is unclear exactly which well-child services are covered or how many exams are allowed annually.[17] Nonetheless, it is clear that only a minority of Alaska children who currently receive no well-child benefits would begin receiving such benefits were they to be mandated by the state. However, the care of children who currently receive benefits may improve under such a mandate as a number of studies have shown that private preventive coverage is generally less than comprehensive, and are generally inferior to those required under Medicaid (EPSDT). We explore this issue further in our discussion of EPSDT below.

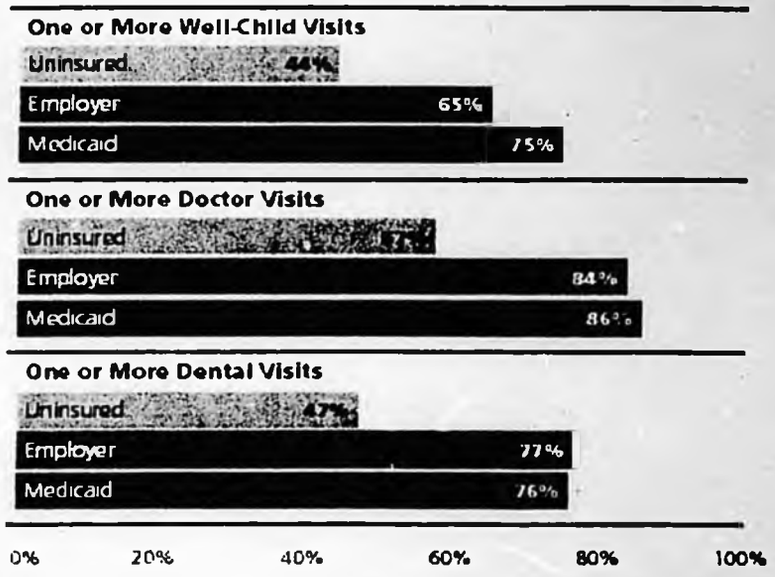
[16] Except for group plans with over 200 members, for which such services are an optional benefit. Information on Premera Blue Cross group plans is available online through *http://www.premera.com*.

[17] Insurance companies operating in Alaska are not required to disclose details of policy agreements, except to regulators who are required to keep such information confidential. We, therefore, have no means of determining exactly how many Alaskans with private insurance are entitled to well-child benefits.

"UPTAKE" OF WELL-CHILD BENEFITS

Research has demonstrated that even when well-child benefits are available, many parents do not take advantage of them, nor do parents typically adhere to recommended exam schedules as their children age. This is a cause for particular concern with regard to low-income families, whose children are more likely to be in poor health, are more likely to have special healthcare needs, and are at greater risk for long-term disability than children in families with higher incomes. In short, these are precisely the children who could benefit most from well-child exams.[18] Figure 1 illustrates the "uptake" of healthcare services by low-income children in 2002.

Figure 1: The Use of Healthcare Services by Insurance Status for Low-Income Children in the U.S., 2002

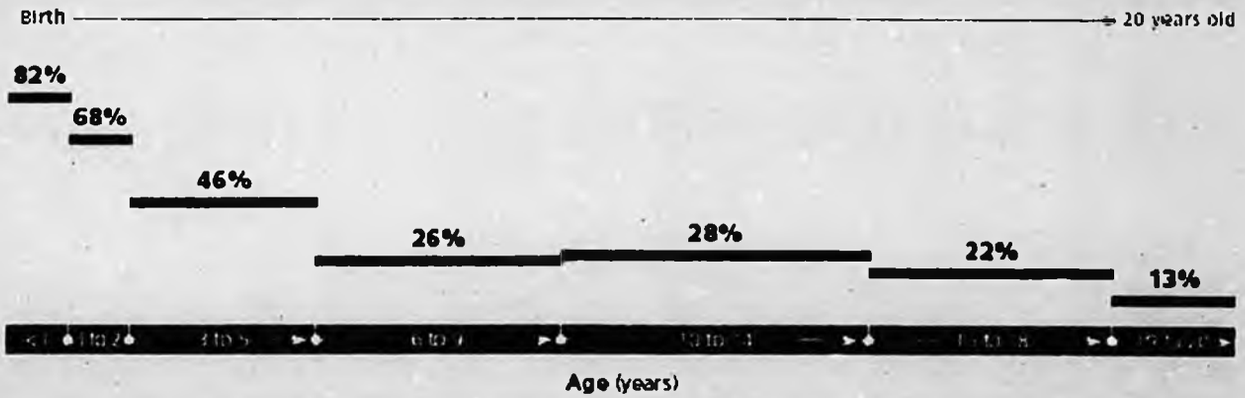


Source: Christine Provost Peters "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," Health Policy Forum Issue Brief No. 819; November 20, 2006.

[18] Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," *Health Policy Forum Issue Brief*, George Washington University, No. 819; November 20, 2006. We include a copy of this document as Attachment G.

Figure 2 shows that even within the coverage group most likely to receive well-child care—those on Medicaid—uptake of available services diminishes rapidly as children age.[19]

Figure 2: Percentage of Children Receiving Medicaid-Funded Well-Child Screening by Age Group in the U.S., 2003



Source: Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," Health Policy Forum Issue Brief No. 819; November 20, 2006.

The above figures suggest that a significant portion of Alaskan children who would benefit most from mandated coverage of well-child care—that is, children from low-income families who are covered by commercial insurance that does not already provide such coverage—would not receive that care or would receive it only for a few years.

INCOME AS A FACTOR IN COVERAGE

Household income is perhaps the single most predictive factor of health insurance coverage and, therefore, for receipt of well-child exams. Because low-income children are less likely to be insured, they are also, as Figure 1 illustrates, less likely to receive well-child care. Table 3 provides further evidence that the uneven distribution of insurance coverage across income levels is such that the children who need preventive care most may not be receiving it.[20]

[19] These figures are from Provost Peters.

[20] Population data are from 2005. Certain poverty data are from 2004. Because population and poverty data may be from different years, and due to the impact of sampling error and other statistical complexities, these data should be seen as estimates only. For the same reasons, and because we used data from different sources, the count of "uninsured," and certain other figures in this table may not precisely match other information in this report. We believe, however, that the proportions of children in certain age groups and of the uninsured are reliable estimates.

Table 3: Insurance Status by Age and Income Level in Alaska, 2004-2005[21]

Ages	Insurance Status	Number of Children	Number of Children in Specified Family Income Groups (Expressed as a Percentage of Federal Poverty Threshold)[1]							
			Below 100%	% of Uninsured	100% to 150%	% of Uninsured	150% to 200%	% of Uninsured	200% and above	% of Uninsured
0 to 18 Years	Total	194,207	23,033		25,050		21,868		124,256	
	Insured	174,587	16,071		22,604		18,831		117,081	
	Uninsured	19,620	6,963	35.5%	2,446	12.5%	3,037	15.5%	7,175	36.6%
0 to 6 Years	Total	69,816	8,966		8,895		9,692		42,264	
	Insured	62,988	5,529		8,055		8,836		40,568	
	Uninsured	6,828	3,437	50.3%	839	12.3%	856	12.5%	1,696	24.8%
7 to 12 Years	Total	63,461	8,463		6,405		7,317		41,276	
	Insured	57,683	6,882		5,636		6,650		38,514	
	Uninsured	5,779	1,581	27.4%	769	13.3%	667	11.5%	2,762	47.8%
13 to 18 Years	Total	60,929	5,604		9,750		4,859		40,716	
	Insured	53,916	3,660		8,912		3,344		38,000	
	Uninsured	7,013	1,945	27.7%	838	11.9%	1,515	21.6%	2,716	38.7%

Notes and Sources: 1) The "Federal Poverty Threshold" is a complex statistical measure used by the U.S. Census Bureau to report population, economic, and demographic data. This measure differs somewhat from the Federal Poverty Guidelines, which is an administrative calculation used to establish eligibility for need-based programs. This table should be viewed as estimates of Alaskan children at certain general income levels rather than an indication of who may qualify for specific income-based assistance programs. Additional information on the differences between poverty guidelines and thresholds is available online at *http://aspe.hhs.gov/poverty/faq.shtml#differences.*

The figures in this table are from the U.S. Census Bureau, "Current Population Survey" of 2005. Certain poverty data are from 2004. Because population and poverty data may be from different years, and due to the impact of sampling error and other statistical complexities, these data should be seen as estimates only. For the same reasons, and because we used data from different sources, some figures in this table may not precisely match other information in this report. The public database for "Current Population Survey" information from several years is available online at *http://www.census.gov/hhes/www/cpstc/cps_table_creator.html.*

There are a number of striking aspects of the data in Table 3. First, over one-third of all children with family incomes below 100 percent of federal poverty threshold are uninsured. This compares to an overall uninsured rate for children in Alaska of about 9.2 percent (see Table 2). Even more alarming, about half of all children from birth to age 6 living in poverty do not have insurance. The research we reviewed indicates that this is the precise group for which society

[21] This table used the "Federal Poverty Threshold," which is a statistical measure used by the U.S. Census Bureau to report population, economic, and demographic data. This calculation differs somewhat from the Federal Poverty Guidelines, which are administrative measures used to establish eligibility for need-based programs. This table should be viewed as estimates of Alaskan children at certain general income levels rather than an indication of who may qualify for specific income-based assistance programs. Additional information on the differences between poverty guidelines and thresholds is available online at http://aspe.hhs.gov/poverty/faq.shtml#differences.

will likely face the greatest expense for corrective healthcare.[22] Perhaps the most remarkable aspect of these data is the fact that *a significant portion of all uninsured children in Alaska may qualify for well-child benefits under **current** public assistance eligibility criteria.*

MEDICAID EPSDT COVERAGE[23]

As you know, the primary public insurance program for children in Alaska is Denali KidCare (DKC).[24] Because DKC is funded in part by Medicaid, federal provisions require implementation of the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). This program requires comprehensive well-child services for Medicaid eligible children, which must include the following:

- Screening Services;
- Comprehensive health and developmental history;
- Comprehensive unclothed physical exams;
- Appropriate immunizations;
- Laboratory tests;
- Lead toxicity screening;
- Health education;
- Vision, hearing and dental services; and
- Other necessary diagnoses, treatments, and other measures as prescribed by law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

Overall EPSDT benefits must meet "reasonable standards of medical practice" as suggested by recognized medical organizations in child health care.[25] In Alaska, these services are recommended at the following ages:

- Birth, 2, 4, 6, 9, 12, 15, 18 and 24 months;
- Aged 3, 4, 5, and 6 years;
- At least every other year after age 6.[26]

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[22] See, for example, Eileen Salinsky, "Clinical Preventive Services: When is the Juice Worth the Squeeze?," *National Health Policy Forum Issue Brief*, George Washington University, No. 806; August 24, 2005. We include a copy of this document as Attachment H.

[23] A comprehensive review of Medicaid and EPSDT coverage is outside the scope of this report. We provide this information only as an indicator of the current status of well-child care in the state and of the potential to expand this care under public insurance in lieu of, or in combination with, requiring coverage of well-child exams by commercial insurers.

[24] Denali KidCare is the name given to the state's public insurance program that is funded in part by Medicaid and the State Children's Health Insurance Program (SCHIP). Further information on Denali KidCare is available online at *http://www.hss.state.ak.us/dhcs/DenaliKidCare/default.htm*.

[25] Further information on EPSDT requirements is available from the Centers for Medicare and Medicaid Services online at *http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/*.

[26] "Alaska Medicaid Recipient Services," Alaska Department of Health and Social Services, Division of Healthcare Services, p. 15; available online at *http://www.hss.state.ak.us/dhcs/PDF/MedicaidRecipientHandbook1.pdf*.

A number of studies have found that the comprehensive requirements of EPSDT generally provide greater well-child benefits than those of commercial insurance policies, which tend to restrict or deny certain services.[27] In Alaska, however, those who are eligible are not fully utilizing this benefit. According to the fiscal year 2005 "Annual EPSDT Participation Report," only 50.75 percent of "total eligibles who should receive at least one initial or periodic screen" actually received that service.[28] Although the federal government is now requiring states to implement programs to increase participation rates, those efforts have not yet been widely successful. Just seven states have met the federal participation goal of 80 percent. Each of those states has initial income eligibility guidelines of at least 200 percent of the federal poverty guideline ($4,167 per month for a family of four in Alaska in 2006).[29] The barriers to participation are manifold, but include low provider participation rates due to inadequate reimbursement for services, lack of parental awareness of the benefits available, and the overall scarcity of healthcare services in many parts of Alaska.

In general, it appears that the number of children who would be impacted by increased efforts to raise participation rates among those currently eligible for EPSDT services may exceed the increases that are possible strictly from mandating commercial coverage of well-child exams. According to data from the U.S. Census Bureau, expanding Denali KidCare income guidelines to 200 percent of federal poverty guidelines would likely increase by several thousand the number of uninsured children who are eligible for services.[30] However, increased education about available benefits and expanding eligibility do little to address the shortage of healthcare providers in certain areas of the state. Although we located no Alaska-specific research in this regard, the healthcare system in many parts of the state likely could not sustain substantial increases in comprehensive EPSDT services. In addition, expanding publicly funded services will clearly increase a Medicaid budget that is already seen by many as being too costly and growing at too fast a rate. It is worth noting, however, that the national average annual per capita spending on children in Medicaid is, at $1,315, about one-third that of other enrollees at $4,011. Also, historic costs per child are less, on average, for Medicaid than for private insurance.[31]

As you know, Chapter 34 SLA 2003 reduced the household income limits for uninsured children and pregnant women from 200 percent of the federal poverty guidelines for Alaska to 175 percent of the guidelines, and converted that percentage into dollar amounts. As a result of this change, fewer children and pregnant women were eligible for Denali KidCare. The federal poverty guidelines typically increase over time, so the income limits, which are fixed at 175 percent of the 2003 guidelines, are only about 160 percent of the 2006 guidelines and 155 percent of the 2007 guidelines. If the federal poverty guidelines continue to increase, Alaska's income guidelines for Denali KidCare will continue to fall as a percentage of the federal poverty guidelines, thereby excluding additional residents from coverage.

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[27] See, for example, pp. 4-5 of Provost Peters.

[28] This report is available online at *http://www.cms.hhs.gov/MedicaidEarlyPeriodicScrn/03_StateAgencyResponsibilities.asp*.

[29] Those states are Georgia, Iowa, Minnesota, Nevada, New York, and Vermont. For further information, see Provost Peters, p. 24. Federal poverty guidelines for Alaska are as of April 1, 2006.

[30] As you know, companion bills currently before the Legislature, SB 87 and HB 140, seek to expand Denali KidCare eligibility guidelines.

[31] Provost Peters, p. 17.

CONCLUSION

The policy question of whether to mandate commercial insurance coverage of well-child visits in Alaska is a highly complex one. A comprehensive review of the question would include an actuarial analysis of the cost-effectiveness of requiring such coverage. Such a review may also include considering ways to expand public health coverage and use of well-child exams for both the currently eligible population and those below a certain level of income not currently receiving such benefits. Other states that have mandated benefits require an exam schedule that is based on, but is more limited than, that suggested by the American Association of Pediatrics. Some mix of these strategies may provide the preventive care Alaskan children need—particularly those in low-income families—while avoiding driving healthcare policy premiums and the Medicaid budget to unacceptably high levels.

I hope you find this information to be useful. Please do not hesitate to contact us if you have questions or need additional information.

LIST OF ATTACHMENTS

Attachment A

"Recommendations for Preventive Pediatric Healthcare," *American Academy of Pediatrics* (AAP)

Attachment B

American Academy of Pediatrics, "CHIRP-Child Health Insurance Reform Plan," a table of state laws mandating well-child exams, provided by Jody Ruskamp-Hatz, Senior Policy Specialist, *National Conference of State Legislatures*

Attachment C

Judith L. Wagner, Roger C. Herdman, and David W. Alberts, "Well-Child Care: How Much is Enough?" *Health Affairs*, Vol. 8, No. 3; Fall 1989

Attachment D

Virginia A. Moyer, M.D. M.P.H., and Margaret Butler, B.A., "Gaps in the Evidence for Well-Child Care: A Challenge to Our Profession," *Pediatrics*, Vol. 114, No. 8; Dec. 2004

Attachment E

"What Policymakers Need to Know About Cost Effectiveness," *Partnership for Prevention*, 2001

Attachment F

"Mandated Health Insurance Benefits: Tradeoffs Among Benefits Coverage, and Costs?" *California Health Policy Roundtable* (a *Kaiser Family Foundation* funded organization), July 2002

Attachment G

Christine Provost Peters, "EPSDT: Medicaid's Critical But Controversial Benefits Program for Children," *Health Policy Forum Issue Brief*, George Washington University, No. 819; November 20, 2006

Attachment H

Eileen Salinsky, "Clinical Preventive Services: When is the Juice Worth the Squeeze?," *National Health Policy Forum Issue Brief*, George Washington University, No. 806; August 24, 2005

NFIB
The Voice of Small Business®

Alaska

May 6, 2007

The Honorable Lesil McGuire
Alaska State Capitol Building
Juneau, Alaska 99801

RE: Senate Bill 170 – Mandatory Health Insurance Coverage for Well Baby Visits

Dear Senator McGuire,

On behalf of the Alaska Chapter of the National Federation of Independent Business, I wish to express our opposition to Senate Bill 170. The Alaska Chapter of the National Federation of Independent Business is the largest small-business advocacy group in the state.

While we understand the concern with health insurance coverage for well baby visits, we must oppose mandatory benefits, especially when directed to a specific health benefit. Small businesses in Alaska budget a portion of their revenues to employee compensation, that includes the cost of health insurance. The distribution of those funds should be left to discussions between employees and employers, without the interference of the state. Mandating this benefit limits the options of employee health insurance programs.

The design of employee health insurance programs should not be determined by the legislature for private employers. Such action is nothing less than an unfunded mandate on small Alaskan employers and their employees. Such benefit mandates can increase the cost of health insurance and may have the ultimate effect of pricing health insurance out of the reach of small employers and their employees.

Sincerely,

Dennis L. DeWitt
Alaska State Director
National Federation of Independent Business

cc: Senate Labor & Commerce Committee

National Federation of Independent Business – ALASKA
P.O. Box 34761 • Juneau, AK 99803 • 907-723-6667 • denny.dewitt@nfib.org

SB

179

25-LS0936\C.1
Chenoweth
3/25/08

AMENDMENT #1

OFFERED IN THE SENATE

TO: SB 179

Page 1, lines 1 - 2:

Delete all material and insert:

""An Act prohibiting a health care insurer who provides health care insurance coverage of a child through family health care insurance from denying enrollment and from disenrolling or eliminating coverage for a dependent child of the insured who is less than 26 years of age.""

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
Phone: (907) 465-3822
Fax: (907) 465-3756
Toll free: (800) 770-3822

Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 179, 25-LS0936\C

"An Act requiring family health care insurance coverage for dependent children who are less than 26 years of age."

SPONSOR STATEMENT

SB 179 mandates family private health insurance coverage for dependent children through age 25. It prohibits a health care insurer from denying or removing enrollment or eliminating coverage under age 26.

Young adults, ages 19-29, are one of the largest growing segments of the U.S. population without health insurance. In 2004 almost 14 million young adults lacked coverage, an increase of 2.5 million since 2000. This rapid change is due in part to their losing coverage under their parents' policies at 19, or Medicaid, or State Children's Health Insurance Program, or graduation from high school or college. Almost half of college graduates and high graduates will be uninsured for a substantial time after graduation.

Age 19 is a crucial year in health insurance coverage. Both public and private insurance plans treat this age as a turning point for insurance coverage. Even if youth go on to college, parents' insurance plans often stop before graduation. Almost all private universities and about one fourth of public universities require health insurance as a condition of enrollment. Forty percent of part-time students and non-students, and 20% of full-time students ages 19-23 are uninsured.

Insurance coverage is important for this generally healthy group of young adults who should be encouraged to start taking responsibility for their own health care. It has been found that 14% of adults 18-29 are obese, an increase of 70% in the 1990s, - the fastest rate of increase among all adults. There are 3.5 million pregnancies each year among the 21 million women ages 19-29. One-third of all diagnoses of HIV are made among young adults. Emergency room visits are far more common among young adults than children or older adults. Most young adults have no regular doctor, no link to the health care system, and more than one-third of those who do require medical attention are often saddled with debt and collection agencies.

States are taking action to mandate coverage for young adults, often allowing for targeted policy options. For example, in 2006 New Jersey required most group health plans to cover single adult dependents up to age 30. Massachusetts as part of its expanded health insurance law in 2006 considered dependents for insurance purposes up to age 25 or for two years after they are no longer claimed on their parents' tax returns. Since 1994Utah has required coverage through age 26, and New Mexico provides coverage for unmarried dependents up to age 25, regardless of school enrollment. Texas in 2003 allowed full-time students up to be covered by their parents' insurance plans to age 25. It is not uncommon, or unreasonable, therefore, that Senate Bill 179 requires offering family health insurance coverage to dependent children up to age 26.

Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help

SARA R. COLLINS, CATHY SCHOEN, JENNIFER L. KRISS, MICHELLE M. DOTY, AND BISUNDEV MAHATO*

For more information about this study, please contact:

Sara R. Collins, Ph.D.
Senior Program Officer
The Commonwealth Fund
Tel 212.606.3838
Fax 212.606.3500
E-mail src@cmwf.org

This is a revision of the issue brief *Rite of Passage*, first released in May 2003. It updates analyses with new data from the March 2005 Current Population Survey, the 2003 Medical Expenditure Panel Survey, and the Commonwealth Fund Biennial Health Insurance Survey (2005). It also provides new information on state legislation and other proposals recently introduced to increase health insurance coverage among young adults.

This and other Commonwealth Fund publications are online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and register to receive e-mail alerts.

Commonwealth Fund pub. 649
Vol. 20

ABSTRACT: Young adults (ages 19 to 29) are one of the largest and fastest-growing segments of the U.S. population without health insurance: 13.7 million lacked coverage in 2004, an increase of 2.5 million since 2000. Young adults often lose coverage under their parents' policies, Medicaid, or the State Children's Health Insurance Program at age 19, or when they graduate from high school or college. Nearly two of five college graduates and one-half of high school graduates who do not go on to college will be uninsured for a period during the first year after graduation. Three policy changes could extend coverage to uninsured young adults and prevent others from losing it: extending eligibility for Medicaid and the State Children's Health Insurance Program beyond age 18; extending eligibility for dependents under private coverage beyond age 18 or 19 regardless of student status; and ensuring that colleges and universities require full- and part-time students to have insurance, and that they offer coverage to both.

* * * * *

OVERVIEW

Young adults between the ages of 19 and 29 represent one of the largest and fastest-growing segments of the population without health insurance in the United States. Often dropped from their parents' policies or public insurance programs at age 19 or on graduation day, they are left to find insurance on their own as they make the transition from high school to work or college.

* *Sara R. Collins, Ph.D., is senior program officer, Cathy Schoen, M.S., is senior vice president, Jennifer L. Kriss is program assistant, and Michelle M. Doty, Ph.D., is senior analyst, all at The Commonwealth Fund. Bisundev Mahato is with the Mailman School of Public Health, Columbia University.*

Yet, jobs available to young adults are usually low-wage or temporary—the type that generally do not come with health benefits. Young adults who are able to go to college full-time may have some protection through their parents' policies, but upon graduation usually lose access to family coverage.

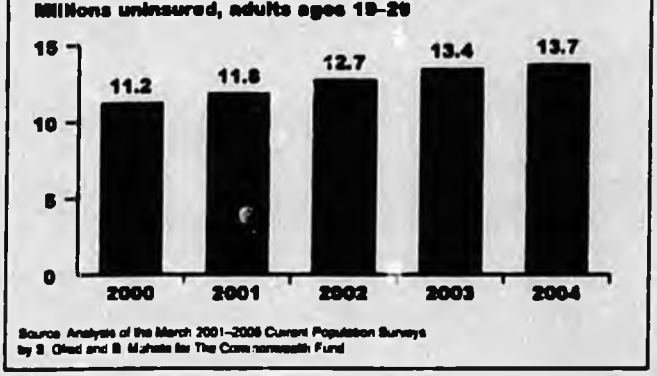
Moving on and off coverage places the health of young adults at risk and subjects them and their families to financial stress just as they are starting out in the workforce. This issue brief assesses the scope of the health insurance problem facing young adults, its causes and implications, and what can be done to ensure stable and continuous coverage. It also offers some targeted policy steps that could help young adults stay insured as they make the transition to independent living.

A LARGE AND GROWING PROBLEM

The number of uninsured young adults ages 19 to 29 climbed to 13.7 million in 2004, an increase of 2.5 million since 2000 (Figure 1). Young adults were the fastest-growing age group among the uninsured over this period, accounting for 40 percent of the increase in the uninsured under age 65. Even though they comprise just 17 percent of the under-65 population, young adults account for 30 percent of the nonelderly uninsured.[1]

By far, the young adults most at risk of lacking coverage are those from low-income households.

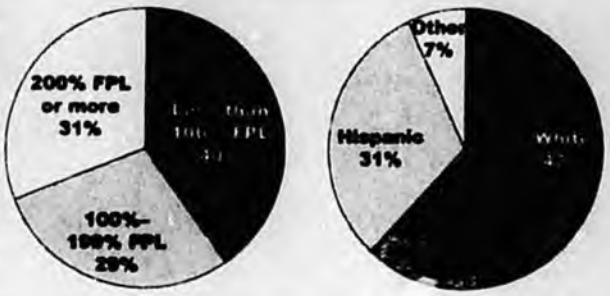
Figure 1. Uninsured Young Adults Up by 2.5 Million in Last Four Years



Source: Analysis of the March 2001–2005 Current Population Surveys by S. Glied and B. Mahato for The Commonwealth Fund.

These individuals, like children and older adults in low-income families, are disproportionately represented among the uninsured. About 23 percent of adults ages 19 to 29 live in households with incomes below 100 percent of the poverty level, but two-fifths (40%) of the 13.7 million young adults who are uninsured live in households with incomes below poverty (Figure 2).[2]

Figure 2. Distribution of Uninsured Young Adults Ages 19–29 by Poverty Status and Race/Ethnicity, 2004



Source: Analysis of the March 2005 Current Population Survey by S. Glied and B. Mahato for The Commonwealth Fund.

Nearly half of uninsured young adults are white. But Hispanics are disproportionately represented among the young and uninsured. While Hispanics comprise 19 percent of adults ages 19 to 29, they comprise 31 percent of uninsured young adults (Figure 2). Hispanics and African Americans are both at greater risk of being uninsured than white young adults: about 36 percent of African Americans and 52 percent of Hispanics ages 19 to 29 are uninsured, compared with 24 percent of whites in that age range (data not shown).

WHAT A DIFFERENCE A YEAR CAN MAKE

Nineteenth birthdays are crucial milestones in Americans' health insurance coverage. Both public and private insurance plans treat this age as a turning point for coverage decisions. Employer health

plans often do not cover young adults as dependents after age 18 or 19 if they do not go on to college. Public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), also typically have one set of income and eligibility standards for children and another for adults, with the 19th birthday as the critical divide.

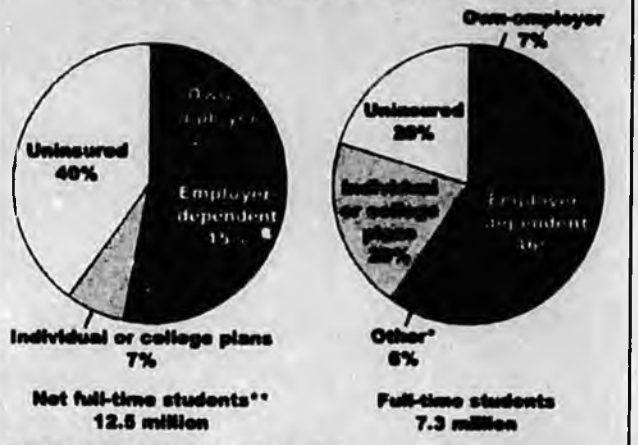
Losing Coverage Under a Parent's Policy

Employer-sponsored health insurance is the mainstay of most family and dependent coverage. Typically, such policies cover children as dependents as long as they meet eligibility rules. Age 18 or 19 tends to be a crucial turning point, after which coverage most often continues only for those young adults who attend college full-time. A 2004 Commonwealth Fund study found that, among employers who offer coverage, nearly 60 percent do not insure dependent children over age 18 or 19 if they do not attend college.[3]

Young adults who enroll in college full-time when they graduate from high school are the most likely in their age group to have insurance coverage, primarily because they are able to maintain eligibility under their parents' employer's policies. A small share of full-time students also gains coverage through plans offered by universities. Roughly 25 percent of public universities and about 90 percent of private universities and colleges require that students have health insurance as a condition of enrollment.[4] Idaho, Massachusetts, and New Jersey have passed either legislative or administrative rulings requiring that students have health insurance in order to enroll.[5] About half (46%) of full-time students ages 19 to 23 receive health insurance through their parents' employer-sponsored plans, while another 20 percent have individual coverage, including college and university plans (Figure 3).

Young adults who are not in school full-time post-high school graduation are much more likely to be uninsured, primarily because it is much harder for them to gain access to employer coverage.

Figure 3. Insurance Sources for College-Age Adults Ages 19–23, 2004



Note: Numbers may not sum to 100% because of rounding.
* Other includes Medicare, Medicaid, and Military. ** Includes part-time students and non-students.
Source: Analyses of the March 2005 Current Population Survey by S. Obed and S. Mahato for The Commonwealth Fund.

Forty percent of part-time and non-students ages 19 to 23 are uninsured, compared with 20 percent of full-time students. Young adults who opt to enter the labor market rather than go to college are unlikely to be eligible for coverage under their parents' policies, and may have difficulty finding a job with health benefits. New entrants to the labor market without college educations are often candidates for positions that are the least likely to come with health benefits—those that pay low wages, are in small companies, or are part-time or temporary in nature.[6] The Commonwealth Fund Biennial Health Insurance Survey (2005) found that 43 percent of all workers ages 19 to 29 who earn less than $10 per hour are uninsured.[7] Almost one-third (31%) of workers between ages 19 and 29 have jobs that pay less than $10 per hour.[8]

Losing Medicaid/SCHIP Coverage at Age 19

Medicaid and SCHIP reclassify all teenagers as adults the day they turn 19. As a result, young adults who had been insured under Medicaid or SCHIP as children typically do not have an option to stay on public coverage unless they are able to qualify for Medicaid as adults. Regardless of

school, work, or dependent status, they lose their eligibility as dependents or children. Most low-income young adults become ineligible for public programs, since eligibility for adults generally is restricted to very low-income parents or disabled adults. Even teenagers with disabilities who qualified for Medicaid before their 19th birthdays have to go through a new set of screening tests to determine whether they will still be eligible for benefits as disabled adults.[9]

Net Impact of the 19th Birthday

As a result of the combined impact of such public and private insurance rules, uninsured rates jump sharply at age 19. Turning 19 increases the risk of being uninsured by more than twofold: the uninsured rate rises from 12 percent among children age 18 and under to 31 percent among those ages 19 to 29 (Figure 4).

Figure 4. Percent Uninsured, Children and Young Adults, by Poverty Level, 2004

Percent Uninsured	Children Age 18 and Under	Young Adults Ages 19–29
Total	12%	31%
<100% FPL	20	54
100%–199% FPL	17	42
≥200% FPL	7	18

Source: Analysis of the March 2005 Current Population Survey by S. Ghadi and B. Mahato for The Commonwealth Fund

Low-income young adults are particularly vulnerable. Among those living in families below the poverty level, more than half (54%) are uninsured, compared with about one of five (20%) children in low-income families. Those with slightly higher incomes (100% to 199% of poverty) fare only marginally better—roughly two of five (42%) are uninsured.

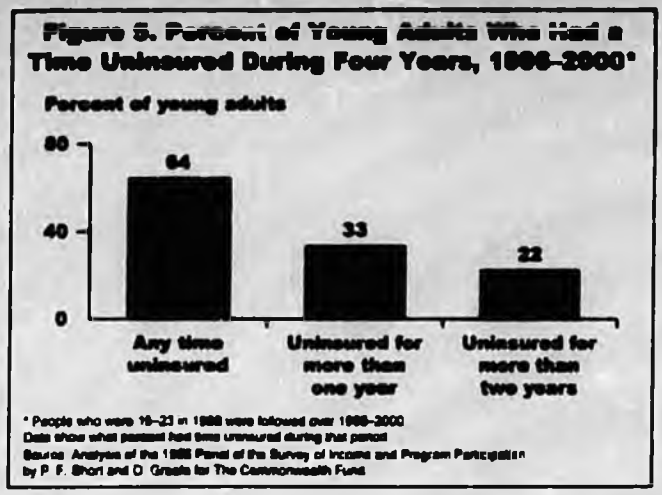
THE (UNINSURED) GRADUATE

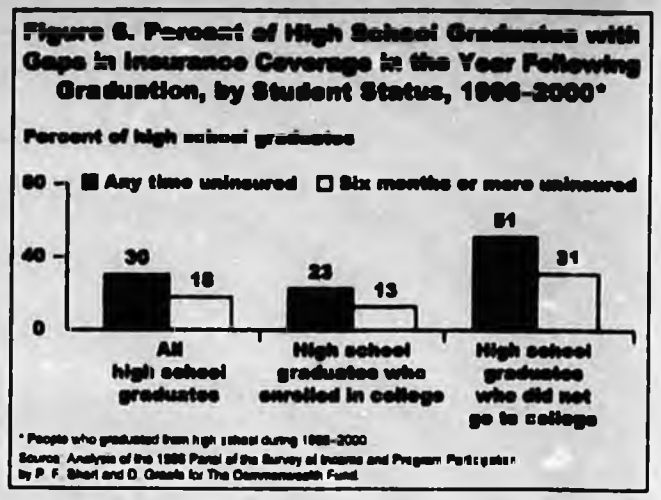
The transitional nature of young adults' lives following their 19th birthday makes it difficult to secure a stable and consistent source of health insurance coverage. Young adults move in and out of school and jobs throughout their 20s. Full-time students might take a leave of absence from school, attend college part-time, or graduate—effectively closing off access to their parents' insurance policies or university-sponsored plans. In addition, job tenure is shorter among younger workers, thus increasing the risk that they will be without health insurance coverage for periods of weeks, months, or even years.

Surveys that track people over time provide an opportunity to examine what happens to the insurance coverage of young adults as they graduate from high school or college or move through their early adult years. The federal multiyear longitudinal survey known as SIPP (Survey of Income and Program Participation) interviewed a sample of people about their health insurance and other characteristics in 1996 and tracked their history through 2000.

The four-year insurance history of all young adults who were ages 19 to 23 at the beginning of 1996 reveals the extent to which life transitions disrupt insurance coverage. Over the 1996–2000 period, two-thirds (64%) of this cohort of young adults went without coverage for at least part of the time (Figure 5).[10] One-third were uninsured for more than a year, while one-fifth were uninsured for more than two years.

Young adults from households with low incomes were most exposed: they were both more likely to go without insurance for at least some period and more likely to endure long periods without insurance. Nearly 80 percent of young adults living under 200 percent of the poverty level were uninsured for at least part of the four-year period; more than half (52%) were uninsured for 13 months or more (Table 1). Reflecting their generally lower incomes, Hispanic and African American young adults were at similarly high risk of losing insurance and experiencing long spells





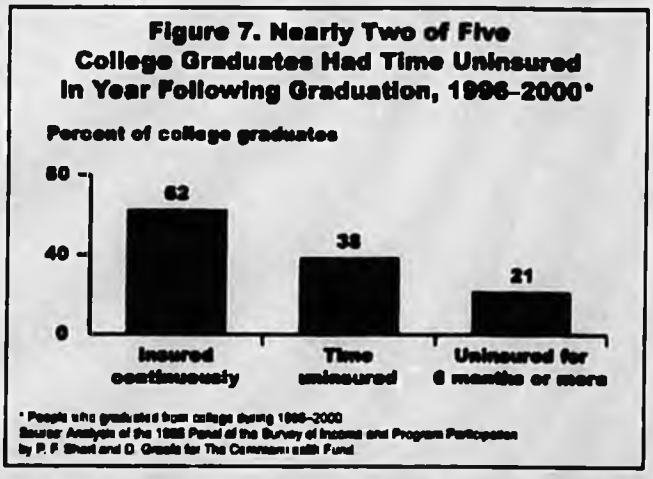
without coverage. Fifteen percent of Hispanic young adults ages 19 to 23 at the beginning of the four years were uninsured for the entire period.

Graduation: High School and College

Tracking people over time also reveals how the major life events of early adulthood noted in this brief disrupt insurance coverage.

Graduation from high school marks a key juncture in the health insurance coverage of young adults. Tracking a sample of young adults in the year following graduation reveals the extent to which college enrollment is correlated with more secure insurance coverage. Among all young adults graduating from high school, three of 10 were uninsured for some time in the year following high school (Figure 6). Half of young adults who graduated from high school but did not go to college were uninsured for some time during the year following their graduation—twice the rate for young adults who attended college that year.

Among those young adults who go to college, the year following their college graduation also can be a time during which connections to the health system are fragile and break down. The protections afforded them by virtue of being a full-time student—coverage through a parent's employer policy or a student health plan—are lost upon graduation. As new, albeit college-educated, entrants to the labor force, they confront similar hazards that high school graduates face: waiting periods, temporary positions, lower-wage jobs, employment in small firms, and job turnover. Of those college students who graduated during 1996 to 2000, 38 percent were uninsured for at least part of the time in the year following graduation, with 21 percent uninsured for six months or more (Figure 7). Based on the experiences of recent graduates, nearly two of five college graduates can expect to spend at least some time uninsured in the year just after graduation.



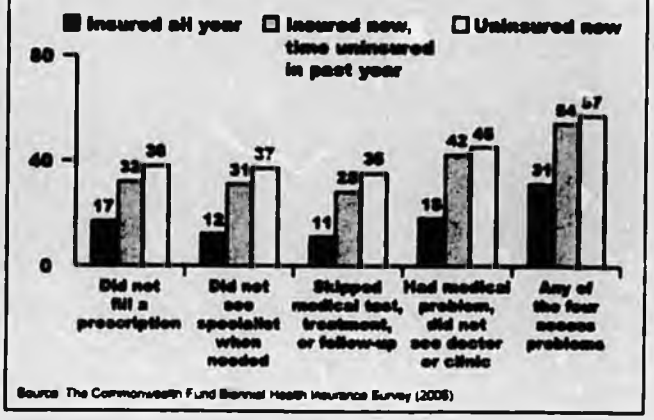
WHY COVERAGE IS IMPORTANT FOR YOUNG ADULTS

Although young adults in general constitute a healthy group, going without insurance disrupts their access to the health care system, introduces barriers to care when it is needed, and leaves young adults and their families at risk for high out-of-pocket costs in the event of a severe illness or injury. Young adults, particularly women, are in need of regular preventive care. If young adults lose their coverage at age 19 or upon graduation from college, their ties with primary care physicians may be severed at precisely the time they should be forming stronger links to the health care system and taking responsibility for their own care. The following are just a few reasons coverage is so important for young adults:

- Fourteen percent of adults ages 18 to 29 are obese. In the 1990s, obesity increased by 70 percent in this age group—the fastest rate of increase among all adults.[11]
- There are 3.5 million pregnancies each year among the 21 million women ages 19 to 29.[12]
- One-third of all HIV diagnoses are made among young adults.[13]
- Injury-related visits to emergency rooms are far more common among young adults than they are among either children or older adults.[14]
- More than 20,000 people with congenital heart disease reach their 19th birthday each year.[15]

The Commonwealth Fund Biennial Health Insurance Survey (2005) shows that being uninsured or having unstable health insurance hampers access to the health care system. More than half (54%–57%) of young adults ages 19 to 29 who either were uninsured for the entire year or had a time without coverage said that they had gone without needed health care because of cost (Figure 8). Forgone care included failing to fill a prescription, not seeing a doctor or specialist when sick, or skipping a recommended medical test, treatment, or follow-up visit.

Figure 8. Lacking Health Insurance for Any Period Threatens Young Adults' Access to Care, 2005

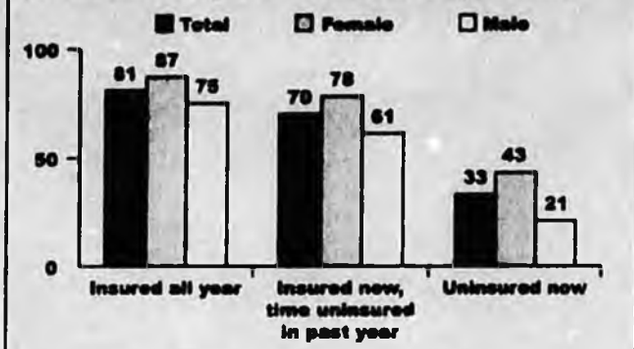


Source: The Commonwealth Fund Biennial Health Insurance Survey (2005)

In addition, uninsured young adults are far less likely than those with coverage to have a regular doctor. Only one-third of uninsured young adults ages 19 to 29 had a regular doctor, compared with 81 percent of those who were insured all year (Figure 9). Uninsured female young adults had regular doctors at about half the rate of young women who were insured all year. Male young adults who were uninsured had the most fragile link to the health care system: just 21 percent had a regular doctor compared with 75 percent of male young adults who were insured all year.

Many young adults have problems paying medical bills or are paying off medical debt over time. More than one-third (35%) of all young adults, both insured and uninsured, said that they had experienced problems with medical bills: having trouble making payments, being contacted by a collection agency because of inability to pay

Figure 9. Young Adults Without Insurance Are Less Likely to Have a Regular Doctor, 2005

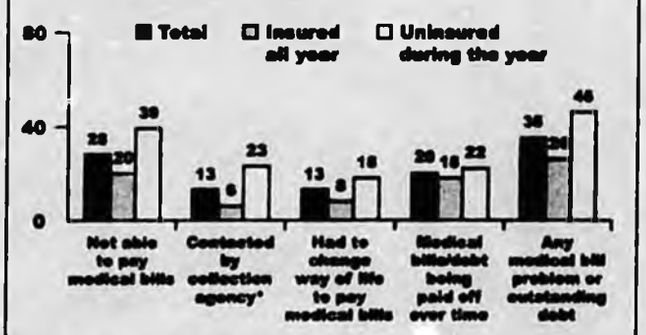


Source: The Commonwealth Fund Biennial Health Insurance Survey (2005)

bills, significantly changing their way of life in order to pay medical bills, or paying off medical debt over time (Figure 10). About one of five (20%) young adults were paying off medical debt over time. Uninsured young adults were the most burdened with medical bills and debt; 46 percent reported at least one of the aforementioned problems.

Contrary to conventional wisdom, young adults appear to value the protection that health insurance coverage provides. The Commonwealth Fund Biennial Health Insurance Survey (2005) found that nearly three-quarters (73%) of employed young adults accept health insurance coverage when it is offered to them, only slightly less than the take-up rate (82%) of workers age 30 or older (Table 2).

Figure 10. Young Adults with Any Time Uninsured Have High Rates of Medical Bill Problems, 2005



* Includes only those whose bill was sent to a collection agency when they were unable to pay the bill
Source: The Commonwealth Fund Biennial Health Insurance Survey (2005)

POLICY OPTIONS TO HELP YOUNG ADULTS STAY INSURED

Health insurance coverage of young adults would be improved by system-wide changes to expand access to and stabilize coverage among the general population. Some recent proposals to achieve near-universal coverage would build on the existing health insurance system, and several have included specific provisions to increase coverage among young adults in current private and public insurance arrangements.[16] For example, The Commonwealth Fund's Karen Davis and Cathy Schoen have proposed a framework for achieving near-universal coverage that includes a requirement for companies to extend coverage to dependent young adults under age 23 through their parents' insurance plan.[17] Other proposals would expand coverage for children as well as young adults, or exclusively target young adults. Senator Jay Rockefeller (D-W.Va.) and Representative Pete Stark (D-Calif.) have introduced legislation creating a Medicare-like program for children that will eventually cover young adults up to age 23.[18] Representative Vic Snyder (D-Ark.) and Senator Blanche Lincoln (D-Ark.) have introduced legislation that would permit states to cover low-income young adults under Medicaid and SCHIP up to age 23.[19] Senate Republicans have proposed financial incentives for colleges and universities that provide or require health insurance for full-time students.[20]

Recent State Action

In the absence of federal action to expand coverage, several states have recently passed or are considering legislation to substantially increase the age

of dependency for young adults for private insurance coverage eligibility status.[21] In general, these laws apply to plans covered under state insurance regulations and thus would not apply to self-insured employers.

In a law taking effect in May 2006, New Jersey will require most group health plans to cover single adult dependents up to age 30 (Table 3).[22] A Colorado law that became effective in January 2006 requires group and privately purchased individual health plans to cover unmarried dependents up to age 25.[23] Dependents must be unmarried or financially dependent, or live at the same address as the parent(s), but eligibility is not dependent on full-time enrollment in school. The New Jersey and Colorado laws both allow insurers to charge a separate premium for extended dependent coverage.

As part of Massachusetts' April 2006 health insurance expansion law, young adults are considered dependents for insurance purposes up to age 25 or for two years after they are no longer claimed on their parents' tax returns, whichever comes first.[24]

Utah has required insurance policies that include dependent coverage to cover unmarried dependents through age 26 since 1994,[25] and New Mexico requires that all insurance policies provide coverage for unmarried dependents up to age 25, regardless of school enrollment.[26]

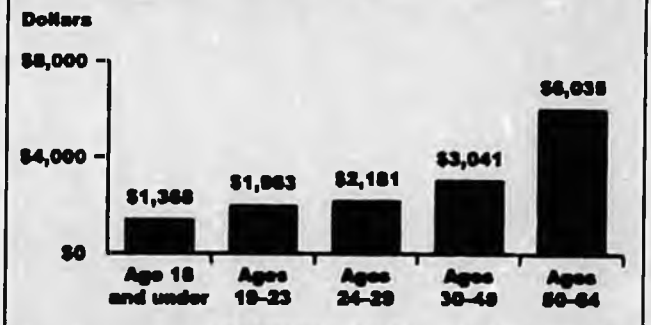
A Texas law effective in September 2003 allows full-time students up to age 25 to be covered by their parents' insurance plans.[27] South Dakota prohibits any insurance provider that offers dependent benefits from terminating coverage before age 19, or 24 if the dependent is a student.[28]

Several state legislatures are considering similar laws. Rhode Island is currently considering a bill that would phase in, through 2009, coverage of unmarried and financially dependent young adults up to age 25.[29] And a California bill that was passed by the state legislature but vetoed by the governor would have prohibited health plans that cover dependent children from establishing a limiting age for coverage of less than 26 years.[30] The bill is expected to be submitted to the governor for consideration again this year.

Targeted Policy Options

Whether as part of a broader expansion plan or implemented on their own, targeted policy options like those recently pursued by states could improve access to coverage for young adults and help them stay insured during the transition to independence. This is a relatively low-cost group to insure: young adults generally are healthier than older adults and therefore have far lower per capita health care expenditures (Figure 11).[31] Indeed, keeping young adults in insurance pools may have the effect of lowering the average costs for group insurance.

Figure 11. Annual Per Capita Total Health Expenditures by Age Group, 2006*



* Inflated to 2006 dollars using actual and estimated annual growth rates in national health expenditures.
Source: Analysis of the 2003 Medical Expenditure Panel Survey by S. Ghosh and S. Manocs for The Commonwealth Fund

Three different public or private policy changes could extend coverage to a substantial portion of uninsured young adults and prevent others from losing coverage in the future.

1. *Extend eligibility for Medicaid/SCHIP public coverage beyond age 18.* Congress could allow or require states to extend coverage to those young adults in Medicaid and SCHIP who lose their eligibility because of age, with federal matching funds provided. Young

adults in households with incomes under 100 percent of poverty are by far the group most at risk of lacking health insurance coverage. Such an expansion would have the biggest impact in terms of lowering the number of uninsured young adults. Young adults with incomes of 100 percent to 199 percent of poverty also lack insurance at a high rate. As proposed in the Snyder and Lincoln legislation, states would have the option of extending coverage up to a target age such as 23, and could phase in coverage one year at a time. Alternatively, Congress could require states to extend coverage to those currently enrolled in the programs and who "age off," just as states are now required to extend Medicaid coverage to those who become ineligible because of higher earnings.[32] Such a policy change could help the 2.9 million uninsured young adults ages 19 to 23 with incomes under 100 percent of poverty.

2. *Extend eligibility for dependents under private coverage beyond age 18 or 19.* Private insurers and both public and private employers could be required to define dependent coverage as all unmarried dependents beyond age 18 or 19. As noted above, many states have recently redefined the age at which a young adult is no longer a dependent—from age 25 in Colorado and New Mexico up to age 30 in New Jersey. Some private and public employers already provide such coverage voluntarily. Under the Federal Employees Health Benefits Program, federal employees and members of Congress currently enjoy coverage for unmarried dependent children under age 22.[33] Such an expanded benefit could either be structured as a rider with a supplemental premium or simply be extended to all policies and covered by the family premium. Even increasing the age to 23 could cover an estimated 1 million unmarried, dependent young adults.[34] If the benefit requirement were extended to family policies, the average premium for those plans would rise by about 3 to 5 percent.[35]

3. *States could ensure that all colleges and universities require full-time and part-time students to have health insurance, and that they offer health insurance coverage to both.* Many colleges and universities already require health insurance coverage as a condition of enrollment, and a handful of states (Idaho, Massachusetts, New Jersey) have legislative or administrative rulings requiring all students at local institutions to be covered. Students at these institutions generally can choose to enroll in a school health plan or provide proof of coverage from another source, usually a parent's employer-based plan. The cost of the school plans, which ranges from about $500 to $2,400 per year, is usually added to tuition along with other required fees.[36] Increasing the number of schools that require students to have health insurance coverage and that offer such coverage through state mandates could help cover the 1.9 million part-time and full-time uninsured students ages 19 to 23. Federal or state subsidies for premiums would help offset the costs of insurance coverage for students.

Notes

[1] All analyses of the March Annual Social and Economic Supplement to the Current Population Survey (CPS), 1987–2005, are from S. Glied and B. Mahato, Columbia University, for The Commonwealth Fund. See Methodology for a description of the CPS.

[2] In 2004, the under-65 poverty thresholds were $9,827 for one person, $12,649 for two adults, $13,020 for two adults and one child under 18, and $19,157 for two adults and two children under 18. See C. DeNavas-Walt, B. D. Proctor and R. J. Mills, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, Current Population Reports, Consumer Income (Washington, D.C.: U.S. Census Bureau, Aug. 2005).

[3] S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, Mar. 2004).

[4] Communication with S. Beckley, Stephen L. Beckley & Associates, Inc., Fort Collins, Colo.

[5] Ibid.

[6] S. R. Collins, K. Davis, and A. Ho, "A Shared Responsibility: U.S. Employers and the Provision of Health Insurance to Employees," *Inquiry*, Spring 2005 42(1):6-15; S. R. Collins, K. Davis, M. M. Doty, and A. Ho, *Wages, Health Benefits, and Workers' Health* (New York: The Commonwealth Fund, Oct. 2004); S. R. Collins, C. Schoen, D. Colasanto, and D. A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage. Findings from the 2001 Health Insurance Survey* (New York: The Commonwealth Fund, Mar. 2003); B. Garret, L. M. Nichols, and E. K. Greenman, *Workers Without Health Insurance: Who Are They and How Can Policy Reach Them?* (Washington, D.C.: The Urban Institute, Sept. 2001); S. H. Long and M. S. Marquis, "Low-Wage Workers and Health Insurance Coverage: Can Policymakers Target Them Through Their Employers?" *Inquiry*, Fall 2001 38(3):331–37.

[7] Authors' analysis of the Commonwealth Fund Biennial Health Insurance Survey (2005).

[8] Ibid.

[9] E. Fishman, "Aging Out of Coverage: Young Adults with Special Health Needs," *Health Affairs*, Nov./Dec. 2001 20(6):254–66.

[10] All analyses of the 1996 Panel of the Survey of Income and Program Participation (SIPP) are from P. F. Short and D. Graefe, Pennsylvania State University, for The Commonwealth Fund. See Methodology for a description of the SIPP.

[11] A. H. Mokdad, E. S. Ford, B. A. Bowman et al., "Prevalence of Obesity, Diabetes, and Obesity-Related Health Risk Factors, 2001," *Journal of the American Medical Association*, Jan. 1, 2003 289(1):76–79; T. A. Hillier and K. L. Pedula, "Complications in Young Adults with Early Onset Type 2 Diabetes: Losing the Relative Protection of Youth," *Diabetes Care*, Nov. 2003 26(11):2999–3005; A. H. Mokdad et al., "The Spread of the Obesity Epidemic in the United States, 1991–1998," *Journal of the American Medical Association*, Oct. 27, 1999 282(16): 1519–22.

[12] K. Quinn, C. Schoen, and L. Buatti, *On Their Own: Young Adults Living Without Health Insurance* (New York: The Commonwealth Fund, May 2000).

[13] Ibid.

[14] National Center for Health Statistics, *Health, United States, 2005* (Hyattsville, Md.: NCHS, Nov. 2005), Table 89.

[15] G. Rosenthal, "Prevalence of Congenital Heart Disease," in *The Science and Practice of Pediatric Cardiology*, Second Edition, A. Garson, J. T. Bricker, D. J. Fisher, and S. R. Neish (eds.) (Baltimore: Williams and Wilkins, 1998), pp. 1095–96.

[16] J. M. Lambrew, J. D. Podesta, and T. L. Shaw, "Change in Challenging Times: A Plan for Extending and Improving Health Coverage," *Health Affairs* Web Exclusive (Mar. 23, 2005):W5-119–W5-132; S. R. Collins, K. Davis, and J. M. Lambrew, *Health Care Reform Returns to the National Agenda: The 2004 Presidential Candidates' Proposals* (New York: The Commonwealth Fund, updated Oct. 2004).

[17] K. Davis and C. Schoen, "Creating Consensus on Coverage Choices," *Health Affairs* Web Exclusive (Apr. 23, 2003):W3-199–W3-211.

[18] S. 1303, MediKids Health Insurance Act of 2005; H.R. 3055 MediKids Health Insurance Act of 2005.

[19] H.R. 3040 Health Care for Young Adults Act of 2005; S. 1298 Health Care for Young Adults Act of 2005.

[20] U.S. Senate Republican Task Force on Health Care Costs and the Uninsured, *Building on a Record of Creative Solutions* (May 2004).

[21] See National Conference of State Legislatures, http: /www.ncsl.org/programs/health/dependentstatus.htm.

[22] New Jersey Public Act 2005 c.375, http://www.njleg.state.nj.us/2004/Bills/PL05/375_.pdf.

[23] Colorado H.B. 05-1101 Section 10-16-104.3, C.R.S., http://www.leg.state.co.us/Clics2005a/csl.nsf/fsbillcont3/C496911BCAEEE00987256F5100652C3E?Open&file=1101_enr.pdf.

[24] Massachusetts H.B. 4850, http://www.mass.gov/legis/bills/house/ht04/ht04850.htm.

[25] Utah Code, Title 31A-22-610.5, http://www.le.state.ut.us/~code/TITLE31A/htm/31A17101.htm.

[26] New Mexico H.B. 335, http://legis.state.nm.us/Sessions/05%20Regular/final/HB0335.pdf.

[27] Texas H.B. 1446, http://www.capitol.state.tx.us/cgi-bin/tlo/textframe.cmd?LEG=78&SESS=R&CHAMBER=H&BILLTYPE=B&BILLSUFFIX=01446&VERSION=5&TYPE=B.

[28] South Dakota H.B. 1045, Chapter No. 265, http://legis.state.sd.us/sessions/2005/bills/HB1045enr.pdf.

[29] Rhode Island S.B. 2211, http://www.rilin.state.ri.us/Billtext/BillText06/SenateText06/S2211.pdf.

[30] California A.B. 1698, http://www.leginfo.ca.gov/pub/bill/asm/ab_1651-1700/ab_1698_bill_20050913_enrolled.pdf.

[31] Analysis of the Medical Expenditure Panel Survey (MEPS), 2003, by S. Glied and B. Mahato, Columbia University, for The Commonwealth Fund. See Methodology for a description of the MEPS.

[32] J. M. Lambrew and A. Garson, Jr., *Small But Significant Steps to Help the Uninsured* (New York: The Commonwealth Fund, Jan. 2003).

[33] Federal Employees Health Benefits Program Handbook, see http://www.opm.gov/insure/handbook/fehb28.asp.

[34] Analysis of the March 2005 Annual Social and Economic Supplement to the CPS, S. Glied and B. Mahato.

[35] This estimate is based on the costs of adding the estimated number of adults 19 to 23 who currently do not have employer-sponsored health insurance to different types of family policies. The range reflects the average premium increases resulting from spreading those costs across family policies with dependent children (5%) or all non-single policies (3%).

[36] The range reflects the costs of those school health plans that are consistent with standards recommended by the American College Health Association. Communication with S. Beckley, Stephen L. Beckley & Associates, Inc., Fort Collins, Colo.; L. Rosellini, "Healthcare Headaches," *U.S. News & World Report*, Apr. 15, 2002, p. 52.

Table 1. Months Uninsured Among Young Adults, 1996–2000

	Population in millions	Any part of 4-year period	13 months or more	25 months or more	48 months
Total 19–23*	17	64%	33%	22%	6%
Poverty					
≤ 200% FPL	5	79	52	37	12
> 200% FPL	12	57	25	15	3
Race					
White	12	61	29	18	3
Black	2	65	38	25	11
Hispanic	2	76	52	39	15

* People who were 19–23 at beginning of survey in 1996.

Source: Analysis of the 1996 Panel of the Survey of Income and Program Participation by P. F. Short and D. Graefe for The Commonwealth Fund.

Table 2. Availability of and Workers' Eligibility for Employer Insurance (base: workers ages 19–64)

	Total	Ages 19–29	Ages 30–64
Total (millions)	125.8	26.0	99.8
Eligibility			
Employer offers a plan	77%	71%	78%
Eligible for employer plan	71	62	73
Coverage			
Covered through own employer	57	45	60
Covered through someone else's employer	17	15	17
Covered through public program	4	6	3
Individual	5	5	6
Other	3	6	2
Uninsured	15	23	13
Take-up rate of own-employer insurance	80	73	82

Note: Workers include full-time and part-time workers.

Source: The Commonwealth Fund Biennial Health Insurance Survey (2005).

Table 3. State Laws That Increase the Age Up to Which Young Adults Are Considered Dependents for Insurance Purposes

State	Year law passed or implemented	Limiting age of dependency status	Applies to non-students?
Colorado	2006	25	Yes
Massachusetts	2006	25[1]	Yes
New Jersey	2006	30	Yes
New Mexico	2005	25	Yes
South Dakota	2005	24[2]	No
Texas	2003	25	No
Utah	1994	26	Yes

[1] Or for two years after they are no longer claimed on their parents' tax returns, whichever comes first.

[2] Age 19 for non-students.

Notes: Four states have passed laws to extend the dependency eligibility age for young adults in the military or who are disabled. Pennsylvania requires that full-time students whose studies are interrupted by military service are considered dependents until they finish school, regardless of age; Illinois requires that full-time students whose studies are interrupted by military service are considered dependents for the amount of time they spent serving, up to age 25. Oregon includes disabled adult children in the definition of dependent; Maine requires that children with a mental or physical disability that prevents them from enrolling in school are considered dependents up to age 24.

Source: National Conference of State Legislatures, *Changing Definition of 'Dependent': Who Is Insured and For How Long?* (Washington, D.C.: NCSL). Available at http://www.ncsl.org/programs/health/dependentstatus.htm.

Methodology

Most data in this issue brief are from four surveys: the March Annual Social and Economic Supplement to the Current Population Survey (CPS), 2000–2005; the Medical Expenditure Panel Survey (MEPS), 2003; the 1996 Panel of the Survey of Income and Program Participation (SIPP); and the Commonwealth Fund Biennial Health Insurance Survey (2005). Sherry Glied and Bisundev Mahato of Columbia University, Mailman School of Public Health, provided analysis of the CPS and MEPS. Pamela Farley Short and Deborah Graefe of Pennsylvania State University, Center for Health Care and Policy Research, provided analysis of the SIPP. The authors analyzed the Commonwealth Fund Biennial Health Insurance Survey.

The CPS, MEPS, and SIPP are federal surveys sponsored by the Census Bureau (CPS and SIPP) and the Agency for Healthcare Research and Quality EPS). The CPS, the primary source of information on U.S. labor force characteristics, is conducted monthly on a sample of about 57,000 households representing approximately 140,000 people. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 99,000 households. The MEPS uses an overlapping panel design in which data are collected in a series of five interviews over a 30-month period, with a new panel started each year. The sample size in 2003 was about 13,000 families, representing 33,000 people. The SIPP is a multiyear panel su vey that interviews a sample of households every four months for several years. The 1996 panel was fielded for four years and consisted of abou 37,000 households.

The Commonwealth Fund Biennial Health Insurance Survey (2005) was conducted by Princeton Survey Research Associates International from August 18, 2005, through January 5, 2006. The survey consisted of 25-minute telephone interviews in either English or Spanish and was conducted among a random, nationally representative sample of 4,350 adults age 19 and older living in the continental United States. The analysis in this report is based on 603 adults ages 19 to 29 in the sample. Statistical results are weighted to correct for the disproportionate sample design and to make the final total sample results representative of all adults age 19 and older living in the continental U.S. The data are weighted to the U.S. adult population by age, sex, race/ethnicity, education, household size, geographic region, and telephone service interruption, using the U.S. Census Bureau's 2005 Annual Social and Economic Supplement. The resulting weighted sample is representative of the approximately 212 million adults age 19 and older, including 35.5 million young adults ages 19 to 29.

SB

183

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 5/16/07

FURTHER: (State Affairs)
Judiciary
Finance

Date of 5-Day Notice: 1/24/08
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2/15/08

Labor and Commerce Committee considered SENATE BILL NO. 183

SB 183 REPEAL DEFINED CONTRIB RETIREMENT PLANS

"An Act repealing the defined contribution retirement plans for teachers and for public employees; making conforming amendments; and providing for an effective date."

and recommends:

[ ] be **replaced** with [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

~~fiscal info forthcoming~~				
AOM	2/15/08	✓		

PREVIOUS FISCAL NOTE(S):

[ ] **APPROPRIATION - no fiscal note**

C Bunde	Bunde		✓		
B Davis	DAvis	✓			
	Hoffman			✓	
CHAIR:	ELLIS	✓			

SENATOR KIM ELTON

SB 183 – Restoring Pension Benefits for Public Employees

Sponsor Statement

SB 183 returns guaranteed pension and health care benefits to Alaska public employees. It will make it easier to recruit and retain teachers, police officers, firefighters, and other public employees with no increase in cost.

Analyses by actuaries and the state Division of Retirement and Benefits show that Alaska's defined benefit pension – paying a guaranteed monthly benefit plus health care – costs the same as the new defined contribution system but provides much better benefits. With SB 183, Alaskans get more benefit for the same cost.

SB 183 repeals the laws putting public employees into risky individual savings account plans, and enrolls them in the least expensive pension plans, the current public employee tier III and teacher tier II. The State already administers these tiers for thousands of members, so no new bureaucracy is required.

A few years ago, Alaska beefed up oversight of the pension system: now two actuaries analyze the health of the pension funds, there are more frequent experience studies, and the state stopped the practice of sometimes paying less than the cost of benefits. SB 183 retains these smart reforms, making Alaska pensions stronger than ever.

The K-12 teachers and university professors who educate our children, the police and firefighters who protect our families, and the public employees who serve our state and cities deserve a secure retirement in return for their service.

I respectfully ask for your support.

ALASKA SENATE
STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-4947 • FAX (907)-465-2108
SENATOR_KIM_ELTON@LEGIS.STATE.AK.US

SENATOR KIM ELTON

Memorandum

TO: Sens. Hoffman and Stedman, co-chairs, and Finance Committee members

FROM: Sen. Kim Elton

RE: Defined Benefit/Defined Contribution

DATE: March 30, 2007

Attached are slightly reformatted charts codifying data provided by Buck Consultants in their letter dated March 19, 2007. The Buck letter responds to requests by the committee to disaggregate by tiers data that previously was dumped into only two buckets for comparison purposes—a defined benefit bucket and a defined contribution bucket. Now we have several buckets of data—four PERS buckets (tiers 1-4) and three TRS buckets.

The normal cost charts for PERS and TRS are easy-to-read comparisons of PERS pension and medical costs by tier and TRS pension and medical costs by tier. The third chart, the accrued liability chart, puts dollar amounts to liabilities by tier.

Here are some demonstrable basics revealed by the Buck data:

- the PERS tier 3 DB employees are just slightly more expensive than the new DC employees;
- the new TRS DC employees are very slightly more expensive than the TRS tier 2 DB employees;
- the very slight cost advantage of a PERS tier 4 over a tier 3 is erased when tier 4 employees leave early and take employer dollars that, if left in the system, would help meet pension benefit obligations in the out years; so
- the DB PERS tier 3 and the DB TRS tier 2 fundamentally fixed the problems the governor claimed had to be fixed by his new DC plan.

There also are some other DB/DC inferences that can be drawn:

- recruitment for quality public employees is made more difficult when Alaska is a defined contribution pension system (without even the backstop of the defined Social Security benefit) because professionals can work with other public employers that are just as competitive on wages and almost all of whom provide a defined benefit pension; and
- retention is made more difficult with the portability provisions of the defined contribution because relatively short-term employees can take their contributions as-well-as employer contributions out of the retirement systems and go to

ALASKA SENATE
STATE CAPITOL • JUNEAU, ALASKA 99801-1182 • (907) 465-4947 • FAX (907) 465-2108
SENATOR_KIM_ELTON@LEGIS.STATE.AK.US

another public employer that provides a defined benefit (any federal employer, or any other state, or almost all municipalities or school districts outside Alaska). As we know, a high percentage of teachers and public employees leave before five years and now new DC employees have a special financial inducement to leave—they can cut and run and take the employer dollars, too.

These inferences are now backed with anecdotal Alaska evidence, even after less than a year's experience with tier 4. Further, the anecdotal Alaska evidence mimics the real-life experience of the two states that actually moved to a defined contribution but later back-tracked because of recruitment and retention problems.

Given the instructive Buck numbers that finally compare the immediately previous DB plans to the replacement DC plan and given, too, the cost-sharing bills that will spread the past service costs to employers regardless of tiers, we need to review what we wrought with SB141.

We must not assume our only options now are passing a DC 'fix-it' bill and passing a cost sharing bill that spreads the pain of past service costs. At a minimum we must also decide whether to give new employees a choice of tier 3 or DC in the PERS system or tier 2 and DC in the TRS system. If the cost differences are a wash, why limit the ability of employers to recruit and retain, and limit new employees to a risky defined contribution plan?

Normal Cost

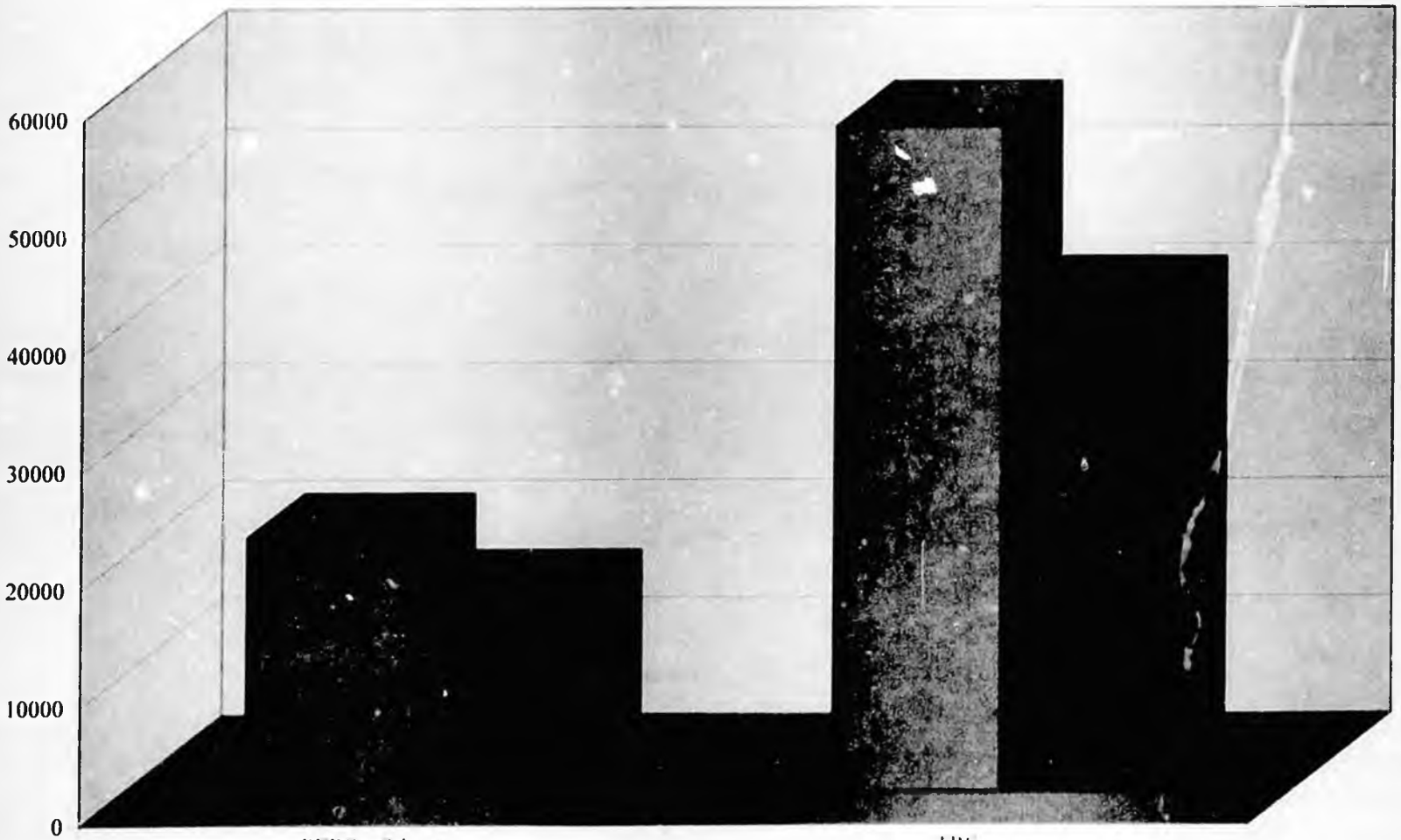
Employer Normal Cost Rate	PERS Pension	PERS Medical	PERS Total	# of Active & Retired
Tier 1 (DB)	9.15%	10.46%	19.61%	26,263
Tier 2 (DB)	5.33%	10.41%	15.74%	10,999
Tier 3 (DB)	1.55%	9.28%	10.83%	18,719
Tier 4 (DC)	5.67%	3.99%	9.66%	2,214

Employer Normal Cost Rate	TRS Pension	TRS Medical	TRS Total	# of Active & Retired
Tier 1 (DB)	7.18%	8.02%	15.20%	11,872
Tier 2 (DB)	2.16%	8.96%	11.12%	7,635
Tier 3 (DC)	7.56%	3.99%	11.55%	754

Accrued Liability

Accrued Liability (DB)	PERS Pension	PERS Medical	PERS Total	TRS Pension	TRS Medical	TRS Total
Tier 1	$5,628,778	$4,036,751	$9,665,530	$3,925,023	$1,816,223	$5,741,247
Tier 2	1,123,559	1,334,674	2,458,233	409,562	347,748	757,309
Tier 3	334,854	386,224	721,078	N/A	N/A	N/A
Total	$7,087,191	$5,757,650	$12,844,841	$4,334,585	$2,163,971	$6,498,556
Assets			$8,442,919			$3,958,939
Accrued Liability			$4,401,922			$2,539,617

Value of Employer-Paid Benefits
(31-year old new employee)



	PERS - Others	TRS
DB Plan	21652	56550
DCR Plan	16791	41667

Based on data provided by Buck Consultants, letter dated May 4, 2006

Assumes a married member with starting salary of $35.5/year.

Alaska Division of Retirement and Benefits

Public Employees' Retirement System (PERS) Plan Comparison Chart

Feature	Tier I 1/1/61 - 6/30/86	Tier II Entered on or after 7/1/86	Tier III Entered on or after 7/1/96	Tier IV Entered on or after 7/1/06
Employee Contribution	Pre-tax employee contribution: 6.75% beginning 1/1/87—all others 7.5% beginning 1/1/87—police and fire 9.6% beginning 7/1/99—school district	Pre-tax employee contribution: 6.75% beginning 1/1/87—all others 7.5% beginning 1/1/87—police and fire 9.6% beginning 7/1/99—school district	Pre-tax employee contribution: 6.75% beginning 1/1/87—all others 7.5% beginning 1/1/87—police and fire 9.6% beginning 7/1/99—school district	Pre-tax employee contribution: 8% all employees Employee may make additional contributions.
Employer Contribution	Determined by annual actuarial valuation.	Determined by annual actuarial valuation.	Determined by annual actuarial valuation.	5% DC Account 1.75% Health Plan - determined by annual actuarial valuation after FY07. HRA - Flat dollar amount per employee based on 3% of the employer's average annual employee compensation. .4% Disability - P/F .3 All others
Vesting	Members vest with 5 years of service.	Members vest with 5 years of service.	Members vest with 5 years of service.	100% vested in employee contributions from inception. Vested in employer contributions based on the following schedule: 25% after 2 years of service, 50% after 3 years, 75% after 4 years and 100% after five years.
Qualifications for Retirement	Normal retirement age is 55, with early retirement at age 50; police/fire members can retire at any age after 20 years of police/fire service; all other members can retire at any age after 30 years of membership service. Early retirement reduction will be 1/2% per month or 6% per year for every year less than the required normal retirement age.	Normal retirement age is 60, with early retirement at age 55; police/fire members can retire at any age after 20 years of police/fire service; all other members can retire at any age after 30 years of membership service. Early retirement reduction will be 1/2% per month or 6% per year for every year less than the required normal retirement age.	Normal retirement age is 60, with early retirement at age 55; police/fire members can retire at any age after 20 years of police/fire service; all other members can retire at any age after 30 years of membership service. Early retirement reduction will be 1/2% per month or 6% per year for every year less than the required normal retirement age.	None for investment account. Taxes and penalties may apply if withdrawn before age 59-1/2. See requirements for Retirement Medical Coverage.
Benefit Calculation Formula	Benefit formula is 2% for first 10 years and all years of service prior to July 1, 1986, 2.25% for the next 10 years, 2.5% per year thereafter. Benefit calculation is determined on the average of the high three consecutive years' salary. Police/Fire - 2% X 10, 2.5% over 10.	Benefit formula is 2% for first 10 years, 2.25% for the next 10 years, and 2.5% per year thereafter. Benefit calculation is determined on the average of the high three consecutive years' salary. Police/Fire - 2% X 10, 2.5% over 10.	Benefit formulas did not change; however, the benefit calculation is determined on the average of the high five consecutive years' salary. The benefit calculation for police and fire members is the average of the high three consecutive years regardless of tier (effective 2002).	DC account balance plus investment earnings. May be received in several different payment options. Payout options include lump sum payments, rollovers to another qualified plan, or annuities. Annuities may be taken as a lifetime annuity, joint and survivor annuity, or for a period certain.
Alaska Cost-of-living increases (COLA)	An Alaska Cost-of-Living Allowance is payable to benefit recipients who remain domiciled in Alaska after retirement. The allowance is $50 or 10% of the base benefit, whichever is greater.	An Alaska Cost-of-Living Allowance is payable to benefit recipients 65 or older or disability benefit recipients regardless of age who remain domiciled in Alaska after retirement. The allowance is $50 or 10% of the base benefit, whichever is greater.	An Alaska Cost-of-Living Allowance is payable to benefit recipients 65 or older or disability benefit recipients regardless of age who remain domiciled in Alaska after retirement. The allowance is $50 or 10% of	None provided.

More detailed information may be found on the Division website, www.state.ak.us/drb, or in the PERS Information Handbook.

*Credited service includes all service used in the calculation of a retirement benefit.

Feature	Tier I 1/1/61 - 6/30/86	Tier II Entered on or after 7/1/86	Tier III Entered on or after 7/1/96	Tier IV Entered on or after 7/1/05
			the base benefit, whichever is greater.	
Post Retirement Pension Adjustments (PRPA) (Inflation Protection)	PRPA increases granted on an ad hoc basis. If an ad hoc is not granted, tier I employees must be age 60 or over or receiving benefits for 5 years to quality for the automatic PRPA. The automatic PRPA legislated in 1986 applied to all members regardless of hire date.	Automatic PRPA adjustments to disabled members, retirees 60 and over, and those who have received benefits for 5 years.	Automatic PRPA adjustments to disabled members, retirees 60 and over, and those who have received benefits for 5 years.	None provided.
Retirement Medical Coverage	Medical coverage is provided to all benefit recipients and their eligible dependents. The retiree medical plan premium is paid by the retirement system	Medical coverage is provided to disabilitants, regardless of age and benefit recipients over age 60 or • Peace officer/fire members with 25 years of police/fire service • all other members with 30 years of membership service and their eligible dependents. The retirement system pays the retiree medical plan premium. Retirees and survivors under age 60 must pay the full premium cost if they want coverage.	Same as Tier II. However, employees must accrue a minimum of 10 years of credited service*, to have system-paid coverage at age 60. Employees with less than 10 years must pay the full premiums as long as they wish to continue medical coverage.	Access to medical coverage at Medicare eligible age with 10 years of service or at any age with 25 years of service for peace officers and firefighters or with 30 years of service for all others. Must retire directly from the system. If not eligible for Medicare, must pay full premium. May use health reimbursement arrangement (HRA) account to pay premiums. Once the HRA is exhausted, member self- pays premiums. When eligible for Medicare, the percentage of premium paid by the retiree or surviving spouse is: 10-14 years of service - 30% 15-19 years - 25% 20-24 years - 20% 25 -29 years - 15% 30 years or more - 10%
Disability Benefits	Disability benefits for members: nonoccupational disability benefits are calculated as a normal retirement. Occupational disability provides 40% of the gross monthly compensation. Different occupational disability formula available before 7/1/76	Disability benefits for members: nonoccupational disability benefits are calculated as a normal retirement. Occupational disability provides 40% of the gross monthly compensation.	Disability benefits for members: nonoccupational disability benefits are calculated as a normal retirement. Occupational disability provides 40% of the gross monthly compensation.	Must be a total and presumably permanent disability whose cause is directly related to performance of duties of the job or an on the job injury. Benefit is 40% of salary, earns service while on occupational disability. Employer continues to make all required contributions as if the member were working, plus the member's required contributions to the DC account, without deduction from the member's disability payment. Disability benefits cease when the member becomes eligible for normal retirement at Medicare eligible age and 10 years of service or at any age with 25 years of service for peace officers and firefighters or with 30 years of service for all others. Medical insurance is available to members receiving disability when member is eligible for a normal retirement.

More detailed information may be found on the Division website, www.state.ak.us/drb, or in the PERS Information Handbook.

*Credited service includes all service used in the calculation of a retirement benefit.

Alaska Division of Retirement and Benefits

Teachers' Retirement System (TRS) Plan Comparison Chart

Feature	Tier I July 1, 1955 – June 30, 1990	Tier II Entered on or after July 1, 1990	Tier III Entered on or after July 1, 2006
Employee Contribution	Pre-tax employee contribution: 8.65% beginning 1/1/91	Pre-tax employee contribution: 8.65% beginning 1/1/91	Pre-tax employee contribution: 8% Employee may make additional contributions.
Employer Contribution	Determined by annual actuarial valuation.	Determined by annual actuarial valuation.	7% - DC account 1.75% Health Plan - determined by annual actuarial valuation after FY07. HRA - Flat dollar amount per employee based on 3% of the employer's average annual employee compensation.
Vesting	Members vest with 8 years of service.	Members vest with 8 years of service.	100% vested in employee contributions from inception. Vested in employer contributions based on the following schedule: 25% after 2 years of service, 50% after 3 years, 75% after 4 years and 100% after five years.
Qualifications for Retirement	Normal retirement age is 55, with early retirement at age 50; teachers can retire at any age after 20 years of membership service.	Normal retirement age is 60, with early retirement at age 55; teachers can retire at any age after 20 years of membership service.	None for investment account. Taxes and penalties may apply if withdrawn before age 59 1/2. See requirements for Retirement Medical Coverage.
Benefit Calculation Formula	Benefit formula is 2% for the first 20 years and all years of service prior to July 1, 1990, 2.5% thereafter. Benefit calculation is determined on the average of the high three contract salaries.	Benefit formula is 2% for the first 20 years, 2.5% thereafter. Benefit calculation is determined on the average of the high three contract salaries.	DC account balance plus investment earnings.
Alaska Cost-of-living increases (COLA)	An Alaska Cost-of-Living Allowance is payable to benefit recipients who remain domiciled in Alaska after retirement. The allowance is 10% of the base benefit.	An Alaska Cost-of-Living Allowance is payable to benefit recipients 65 or older or disability benefit recipients regardless of age who remain domiciled in Alaska after retirement. The allowance is 10% of the base benefit.	None provided.

More detailed information may be found on the Division website, www.state.ak.us/drb, *or in the TRS Information Handbook.*

Feature	Tier I July 1, 1955 – June 30, 1990	Tier II Entered on or after July 1, 1990	Tier III Entered on or after July 1, 2006
Post Retirement Pension Adjustments (PRPA) **(inflation protection)**	PRPA increases granted on an ad hoc basis. If an ad hoc is not granted, tier I employees must be age 60 or over or receiving benefits for 8 years to qualify for the automatic PRPA. The automatic PRPA legislated in 1990 applied to all members regardless of hire date.	Automatic PRPA adjustments to disabled members, retirees 60 and over, and those who have received benefits for 8 years.	None provided.
Retirement medical Coverage	Medical coverage is provided to all benefit recipients and their eligible dependents. The retiree medical plan premium is paid by the retirement system.	The retirement system pays the retiree medical plan premium for all disabilitants regardless of age, for retirees and survivors over age 60 and for retirees with at least 25 years of membership service. This coverage includes eligible dependents. Retirees and survivors under age 60, with less than 25 years of membership service must pay the full premium cost if they want coverage.	Access to medical coverage at Medicare eligible age with 10 years of service or at any age with 30 years of service. Must retire directly from the system. If not eligible for Medicare, must pay full premium. May use health reimbursement arrangement (HRA) account to pay premiums. Once the HRA is exhausted, member self- pays premiums. When eligible for Medicare, the percentage of premium paid by the retiree or surviving spouse is: 10-14 years of service - 30% 15-19 years - 25% 20-24 years - 20% 25-29 years - 15% 30 years or more - 10%
Disability Benefits	Disability benefits are 50% of base salary, plus 10% for each eligible dependent child up to a maximum of 4 children.	Disability benefits are 50% of base salary, plus 10% for each eligible dependent child up to a maximum of 4 children.	Must be a total and presumably permanent disability whose cause is directly related to performance of duties of the job or an on the job injury. Benefit is 40% of salary, earns service while on occupational disability. Employer continues to make all required contributions as if the member were working, plus the member's required contributions to the DC account, without deduction from the member's disability payment. Disability benefits cease when the member becomes eligible for normal retirement at Medicare eligible age and 10 years of service or at any age with 30 years of service. No medical insurance until eligible for normal retirement.

More detailed information may be found on the Division website, www.state.ak.us/d.b, *or in the TRS Information Handbook.*

Division Follows Retirement Legislation—
PERS Technical Clarification Bill Passed by Legislature

The 1st Session of the 25th Alaska Legislature ended late in the night on May 16th. During the session, the Division was tracking the following legislation (see below). Of the bills listed, only House Bill (HB) 95 (Operating Budget), SB 53 (Capital Budget) and SB 123 (Technical Clarification) passed out of the legislature this session. Bills not passed in the 1st Session will carry over into the 2nd Session that begins January 15, 2008. The following table lists each bill with its status and a summary:

	Status	Summary
HB 12 Full funding of PERS/TRS in seven years	In House (H.) State Affairs since January	Requires payoff in seven years of all TRS liability and state's share of PERS liability.
HB 13 Pension Obligation Bonds	Passed H. on April 26. Referred to S. Finance	Authorizes government employers to issue pension obligation bonds to help reduce unfunded liability.
HB 95 **Operating budget**	Signed into law on June 29	**Section 15 of HB 95 provides funds for employer relief for the PERS and TRS.**
HB 97/SB 52 State aid to PERS/TRS school district employers	In H. Finance since Feb. 22 and S. Finance since Jan. 19	Appropriates funds to reduce PERS & TRS school district employer costs due to increased employer contribution rates.
HB 129 Past service cost offset account	In H. State Affairs since mid-February	Establishes an account to aid PERS employers, other than the state, pay for annual past service contributions.
HB 139/SB 83 Supplemental appropriations for tax consulting/potential litigation	In H. and S. Finance since mid-February	Appropriates funds to the division for tax consulting services and an investigation relating to potential litigation on behalf of the PERS & TRS.
HB 179 Cost share plan to eliminate unfunded liability	Referred to H. Finance on April 4	Obligates the state to pay 80% of unfunded liability, other employers 20%, and raises contribution rate for active employees by 5% above current levels.
SB 53 **Capital budget**	Signed into law on June 29	**Section 55 of SB 53 provides funds for employer relief for the PERS and TRS.**
SB 123 **Technical clarification bill**	Signed into law on June 6	**Clarifies retirement reform legislation passed in 2005 (SB 141) that created defined contribution plans for the PERS and TRS.**
SB 125 PERS cost-share	H. amended version transmitted to S. on May 12	Creates cost-share plan for PERS (like TRS) that has same contribution rate for all participating employers.

You can follow the status of these bills and find more detailed information, including the full text, at www.legis.state.ak.us/basis/start.asp, the "Bill Action and Status Inquiry System" (BASIS) page on the Alaska Legislature's website. You can also go to the Division's home page, www.state.ak.us/drb, and click on the "**Legislation**" link under "**Headlines**." This will take you to a listing of bills under consideration or bills that have passed, back to the year 2000. If you do not have access to the Internet, contact your local Legislative Information Office (LIO). You can reach the Juneau LIO by calling (907) 465-4648.

Position Paper Supporting
Senate Bill 183

The Public Safety Employees Association commends Senators Kim Elton, Lesil Mcguire, Johnny Ellis, and Bill Wielechowski for introducing SB 183. The bill gives PERS and TRS employees hired after July 1, 2006, the option of leaving the defined contribution plan and entering the defined benefit plan. New employees will become members of the defined benefit plan after the effective date of the statute, should SB 183 become law.

There have been numerous speculations that the difficulty recruiting police officers is because people aren't interested in working as cops nowadays. Is this because being a police officer is a less honorable profession today than it was 20, 30 or 50 year ago? I think not. There were simpler times when an officer's only real concern was, so called, "fighting the bad guys" to protect society. Today, the officer is troubled by a society where civil law suits are out of control; a work environment riddled with over-zealous policies, voluminous procedure manuals, internal threats such as potential criminal charges even for small practical jokes or acts of levity, armchair scrutiny of split-second life-threatening decisions, job security threats based upon often unfounded allegations, enjoying fewer rights to job and life than the criminals they arrest, training and education demands that rival the private sector; a court system that considers officer's testimony not credible without audio or video recordings; management philosophies stuck in the 1950's; and, compensation packages stuck in the 1960's to 1980's. This is a great work, to be sure, and those in the profession today are no less dedicated to the cause than their predecessors; but, the anguish is also great when the agencies and society they love and have sworn to protect no longer love them. The profession has a toll and currently too much is being paid by the officers.

Consequently, the Department of Public Safety and most municipal police departments struggle to hire enough recruits to staff them to fully authorized strength. As more laws are enacted to curb crime, Alaska must hire the necessary number of public safety employees to insure that these laws are enforced. Increased crimes involving gangs, drugs, and the internet supplement conventional crimes involving violence, larceny, burglary, traffic, and theft violations. The public will be safer when public safety is at full strength to enforce laws against those who choose to break them.

Hiring the most qualified and prepared prospects for careers in public safety and encouraging public safety officers to continue their careers are equally important. One valuable tool that the State of Alaska historically used to both retain and attract persons to peace officer positions was its retirement system. Alaska competes with other state and city departments, the military, and even private security firms for officers and the defined benefit retirement system served as a valuable recruiting tool. Restoring defined benefit retirement will make Alaska more competitive.

The defined benefit program has also been a valuable retention tool. Each year of work means increased retirement. We are now concerned that the defined contribution plan may actually encourage shorter lengths of service by officers in Alaska. The retirement system for those hired since July 1, 2006, accommodates an officer who becomes trained in Alaska, becomes an experienced asset to Alaska, establishes a 401K type savings account, then, decides to take full advantage of the portability of the retirement plan and leaves our state for another. Remember, this officer not only takes his or her 401K but also removes a valuable asset to another state that was trained and experienced at Alaska's expense.

As our experience drains to other states, Alaska will find itself investing more training dollars than necessary to offset the loss. Restoring a retirement program that is an incentive for recruitment and an encouragement for continued service is good public policy. Such a program is a prescription for improved public safety and greater peace of mind by those who depend on the men and women of public safety to keep their communities safe.

Certainly, my testimony today will not persuade all to return to a defined benefit retirement. However, it is my hope that you will pass this bill out of this committee and allow it to be heard by the next. Thank you.